A Report of

The Santa Clara County Board of Supervisors'

TASK FORCE ON AIDS

Presented to the Board of Supervisors

March 17, 1987

87 00941

AIDS COMMUNITY TASK FORCE

MEMBERS

Ken Yeager, M.A.
Chairperson, AIDS Task Force
Treasurer, BAYMEC

Wiggsy Sivertsen, M.S.W.
Vice Chairperson, AIDS Task Force
Professor in Counseling Services at
San Jose State University
Vice President, BAYMEC
Member of Board of Directors, ARIS

John Ashworth
Councilperson, City of Campbell

Roger P. Kennedy, M.D.
Chairman, Dept. of Medicine,
Kaiser Foundation Hospital, Santa Clara
Co-Chairperson, Santa Clara County,
Medical Society AIDS Task Force

Robert O. Mackler, M.A.
Director, Hospital Conference of
Santa Clara County

Sharron Miller, R.N., M.S.N.
Hospice Program Manager,
Visiting Nurses Association
Member of Board of Directors, ARIS

Helen M. Miramontes, R.N., M.S.N.
President, California Nurses
Association
Member of Board of Directors, ARIS

David A. Stevens, M.D.
Chief, Division of Infectious Diseases,
Santa Clara Valley Medical Center
Professor of Medicine,
Stanford University
Member of Board of Directors,
Institute for Medical Research

Ron Taylor, M.Div.
Parole Agent,
California Youth Authority
Member of Board of Directors, BAYMEC
Member of Board of Directors, ARIS

The Task Force would like to thank the Santa Clara County Public Health Medical Services AIDS Project, Santa Clara Valley Medical Center, the ARIS Project, the Dept. of Social Services, BAYMEC, Terri Iacino, Arthur Morris, and Paul Morrell, for their assistance in preparing this report. Special thanks goes to Marjie Christiansen, Medical Services Division, for typing this report.

TABLE OF CONTENTS

ATTACHMENTS

(Total of 22 pages)

a. PROPOSAL - from BAYMEC
to the Board of Supervisors to
Provide Adequate Service to AIDS
Patients In Santa Clara County . . . . . 1 page

b. MEMO - Feb. 3, 1986, to
Sally Reed, County Executive,
From J. Kennedy Bartholet,
Health Services Administrator
Re: Acceptance of Reports Concerning
BAYMEC Proposals for AIDS Education and
Counseling Services . . . . . 5 pages

c. MANUAL - Nursing Services Policy
SCVMC, Sheriff's Dept. Medical Unit,
Re: AIDS and ARC . . . . . 3 pages

d. MANUAL - SCVMC Infection Control
Re: Diseases Transmissible by Blood and
Body Fluids, e.g., AIDS . . . . . 6 pages

e. MEMO - Dec. 19, 1986, to Ken Yeager
from David Stevens, M.D.
Chief, Div. Infectious Diseases
Re: Infection Control in Jails . . . . . 1 page

f. DRAFT - December 24, 1986
Facility, Master Plan Validation
Elmwood Correctional . . . . . 2 pages

g. MEMO - Dec. 3, 1986, to
Dianne Mc Kenna, District 5
From Joanne Hue, Deputy County Counsel
Re: AIDS Anti-Discrimination Ordinance . . . . . 4 pages

1. EXECUTIVE SUMMARY:

The Task Force obtained data from a variety of sources to develop predictions for the number of AIDS cases in Santa Clara County by 1991 and for the medical costs and needs as a result of these cases. We conclude that by 1991 there will be approximately 3,400 cases of AIDS and 22,100 cases of ARC diagnosed within the County. The medical costs to care for these patients in 1991 will be approximately $144 million. Cumulative costs will be much greater.

The Task Force estimates that approximately one-third of the county's AIDS patients may seek care at the Santa Clara Valley Medical Center (SCVMC). To care for these patients, the Task Force recommends that:

Recommendations for Medical Needs:

1. The County should expand its resources at Santa Clara Valley Medical Center. This would include recruitment of a supervising specialist physician to coordinate and supervise activities related to AIDS.

2. The County should assist in the development of community resources. The number one priority is the development of a specialized hospice or skilled nursing facility for post-acute care.

3. With the guidance of the Hospital Conference and the Medical Society, each hospital should develop policies to facilitate care of AIDS patients. They should be able to identify physicians who are knowledgeable about AIDS treatment and are familiar with community resource services.

4. A long-term answer to the problem posed by AIDS lies in research. Research by county employees and other persons in the county should be encouraged from all levels of government, and by private and corporate support.

Recommendations for Education:

Until a vaccine for the AIDS virus is developed, the only way to slow down the spread of AIDS is through education. Education must be intensified and the media utilized to the fullest if non-infected people are to escape infection. Education must be directed toward all groups in the population, and culturally-sensitive materials must be developed. To accomplish this, the Task Force recommends that:

1. A wide-range of printed and audio/visual materials should be produced or purchased, including materials targeted to Latinos, Blacks, Asians, American Indians, women and youth.

2. An additional health educator should be hired to develop educational programs, do outreach to schools, and to assist in the presentation of educational programs in the schools.

3. An additional health educator should be hired to develop and deliver programs on women's issues.

4. An AIDS Clinical Nurse Specialist should be hired to provide expertise to clinics currently operated by the Santa Clara County Health Department.

5. Additional funds should be allocated in future years to produce and update AIDS educational materials and to hire more personnel.

6. The Board should work in a collaborative manner with external funding sources, groups and organizations to provide the widest possible distribution and development of educational materials.

Recommendations to Meet Social Service Needs:

As the number of AIDS cases increases in the County, the demand for services provided by County departments and contract agencies will increase. We investigated programs and services available to AIDS patients and made recommendations on how to meet the present and future needs. The Task Force recommends that:

1. An Adult Service Worker Team should be created to assist AIDS/ARC clients with SSI advocacy, health placement services, eligibility requirements, and supportive counseling in each DSS district office. Placement and funding of this team needs further exploration.

2. Mandatory ongoing training in AIDS-related issues should be provided by the Health Protection's AIDS Project to all DSS personnel who have direct contact with AIDS/ARC clients. This includes receptionists, eligibility workers, social workers, and their supervisors. Such training should also be required for Public Guardian workers on the same basis.

3. AIDS/ARC patients need to have priority service due to the immediacy of the disease. These priority services would include reserved vouchers for housing, appointment scheduling and in-home support services.

4. Contract agencies need a stipulation in their agreements with the County to provide AIDS training to their personnel, i.e., home-health workers, residential substance abuse program personnel, etc. Further, their agreements should explicitly specify the provision of services to AIDS clients who are eligible for them.

5. A multidisciplinary approach to delivering services to AIDS/ARC patients should be established. This would involve a team of trained personnel that would coordinate the delivery of comprehensive health care services to the client in order to facilitate case management.

6. The position of Multidisciplinary Team Coordinator should be created to ensure the efficient delivery of services to AIDS/ARC clients and to avoid duplication of efforts.

7. The Board should refer to the Paratransit Coordinating Council the recommendation that service providers work in cooperation with the ARIS Project to guarantee transportation of AIDS/ARC clients.

Recommendations to Meet Pyschosocial Needs:

1. The contract with ARIS Project should be renewed in fiscal year 1987-88. In all probability, an increase in funding in fiscal year 1988-89 will be necessary.

2. County Mental Health should provide in-house training to contract agencies to guarantee that they respond properly to the psychosocial needs of AIDS/ARC clients.

3. All Mental Health district offices should be required to have a representative on the Mental Health Committee for AIDS.

4. A tracking system to measure the impact of AIDS/ARC on Mental Health services should be established.

5. All contract agency contracts should include provisions to provide services to eligible people who have AIDS or ARC.

Recommendations to Meet Housing Needs:

1. The Board should direct the Administration and County Counsel to include language in all contracts to require that service not be denied individuals with AIDS/ARC when providing the following:
   * Day Center Activities
   * Low Income Housing
   * Independent Care Services
   * Respite Care
   * Hospice Care
   * Skilled Nursing Care
   * Day Care

2. The Board should direct the County Executive to report back within 90 days on the need through 1991 for additional housing facilities and services that may be necessary for people with AIDS/ARC.

Recommendations to Meet Needs in the Jails:

The Task Force investigated the protocol issued for the jail which requires that AIDS and ARC inmates, and inmates who test positive for the AIDS antibody, be placed in medical isolation at the main jail. We recommend that:

1. The policy to put HIV antibody positive inmates in maximum-security medical isolation should be discontinued.

2. HIV antibody positive inmates should be granted the same privileges as other inmates, such as full participation in work furlough programs and trusteeships.

3. Ongoing AIDS education should be made available to all inmates, and be mandated for male and female inmates who have been sentenced. A procedure should be developed that assures AIDS education at the earliest possible time.

4. The Sheriff should report to the Board on his efforts to eliminate IV drug abuse, tattooing and rape in the jails.

5. An appropriate AIDS protocol should be issued for the Women's Detention Center.

6. Condoms should be available to inmates.

7. Plans to house HIV antibody positive inmates in the isolation ward of the new jail should be overturned.

8. A special AIDS module should not be part of the Elmwood Master Plan.

9. Education of Sheriff's deputies on AIDS should be continued by the County Health Protection's AIDS Project. Jail administrative staff also should be educated about AIDS.

10. The Sheriff should obtain ongoing input from experts knowledgeable in Infection Control to develop AIDS programs and write AIDS policies.

11. The County Executive's Office should establish a mechanism to review procedures in all County correctional institutions to determine if policies regarding persons with AIDS, ARC or who are HIV antibody positive are medically appropriate and necessary.

Recommendation for Legislation Against Discrimination:

Because of the rise in the number of AIDS discrimination cases in other cities and the known cases of AIDS discrimination in Santa Clara County, the Task Force recommends that:

1. The Board of Supervisors should adopt an AIDS anti-discrimination ordinance affecting the areas of employment, housing, access to medical services, access to paramedical services, banking and lending institutions, and HIV testing.

Recommendations for the Future of the AIDS Community Task Force:

1. The existence of the Task Force should be extended for another year.

2. The Board of Supervisors should co-sponsor a public hearing on AIDS with the Task Force.

The Human Side of AIDS:

Behind each number of an AIDS case is a real person. The Task Force believes that it is important for the Board of Supervisors, county officials and the public to understand the effect AIDS has on people's lives. Therefore, we begin the report with three case histories of people who have been diagnosed with the disease.

2. THE HUMAN SIDE OF AIDS

Dry statistics can not convey the impact of AIDS in human terms. We hope that the following three cases will help illustrate the impact of the disease on the patient and on the medical profession.

Case history #1.

Arnold (not his real name), who in 1986 was 30 years old and a part-time student, had been generally well throughout his life and had received his routine care from a private pediatrician and then from a private internist. One parent was employed by a local governmental agency. The other parent is deceased. He lives at home with his family. His pertinent social history included experimentation with intravenous drugs as a teenager and bisexual experiences while in the armed forces. In 1982 he developed hepatitis, which may have been homosexually transmitted. In the mid-1980s, Arnold visited the Santa Clara Valley Medical Center (SCVMC) Emergency Room for an athletic injury and again for a dermatologic consultation for a skin condition. In 1985 he had a physical examination performed at SCVMC for employment with a county agency and was found to be in excellent health.

In the spring of 1986 he was studied by his private internist because he suffered from fever, productive cough, shaking chills, burning sores in his throat, fatigue and weight loss. He was found to have abnormal liver function, and a chest x-ray revealed a lung infiltrate. ARC was suspected, and he was referred to SCVMC because of his physician's wish for further work-up by the Infectious Diseases group, because of their experience in managing AIDS patients, and because the patient was concerned about his limited ability to pay (he lacked insurance).

In the SCVMC clinic he was found to have a fungal infection of his throat, a herpes infection of his mouth, lesions in the retina of both eyes, elevated protein in his blood, and a weakened immune system. He was studied with blood tests, x-rays, and cultures for possible pneumonia, tuberculosis, and generalized viral and parasitic infections. Treatment for the fungal infection was started. He was referred to the County Health Department test site for HIV antibody testing and was found to be positive.

In June he developed shortness of breath for three days and was hospitalized at SCVMC for 20 days. Bronchoscopy was performed and a lung biopsy revealed pneumocystis infection. The patient now met the CDC criteria for AIDS. Urinary infection with cytomegalovirus was also diagnosed. Treatment with acyclovir for the persisting herpes was initiated, as well as an oral trimethoprim-sulfa drug combination for pneumocystis. However, his white blood cell count fell,

presumably due to the latter medication, necessitating therapy with pentamidine by intramuscular injections. A work-up for generalized bacterial or fungal infection was performed. Consultations with the Dermatology, Pulmonary, and Infectious Disease services were necessary during the hospitalization.

Arnold expressed considerable concern about his family's discovering his diagnosis in an untimely fashion. The Department of Social Services referred the patient to the Aris support group and to a minister for support and counseling, and assisted in enrolling the patient in the MediCal program. He was discharged in July with his lung infection cleared. In August he applied for the disability program, assisted by his SCVMC physicians and the Department of Social Services.

In September he was readmitted to SCVMC after a transient episode of inability to use his hand properly and difficulty with his speech. A transient stroke was suspected. The results of a spinal tap were normal, but a computerized tomographic x-ray of his skull suggested a mass in his brain posteriorly. His white blood cell count was noted to be low again. Recurrent fungal infection of his mouth made it difficult for him to eat; therapy was re-instituted for this infection.

He was discharged for further work-up in the Infectious Disease Clinic as an outpatient, where a nuclear magnetic resonance scan of his skull suggested no brain abnormality. Arnold was severely depressed and was referred to a psychiatrist, who initiated antidepressant drug therapy.

In November he had an episode of focal visual loss and numbness of his fingers. This was thought possibly related to low blood sugar from his earlier pentamidine therapy. Inner ear inflammation was noted and consultation was obtained from an otolaryngologist. Arnold was enrolled in an experimental drug protocol for azidothymidine (AZT) therapy of AIDS, involving cooperation between the SCVMC Pharmacy and the SCVMC Division of Infectious Diseases, the National Institutes of Health (U.S. Public Health Service) in Bethesda, Maryland, and the Burroughs Wellcome Co. in North Carolina.

Later that month he had his third SCMVC admission for transient numbness of his hand, difficulty in speech and hearing, and soiling himself. The diagnosis was felt to be a panic attack resulting from depression, and he was discharged on his second hospital day.

In December it was discovered that his confusion caused him to be taking the incorrect AZT dose. Possible central nervous system infection with HIV was suspected. A fungal infection of his skin was noted. A work-up was initiated for possible lymphoid cancer because of persisting elevated blood proteins. In January 1987 he had his 21st outpatient visit at SCVMC

since his initial work-up in the spring of 1986 for these conditions.

Case history #2.

George (not his real name) was a 37-year-old male at the time of his death in December, 1986. He was employed in the photography department of a local high-tech firm and had continued to work through much of his illness. He was initially bi-sexual, but in more recent years had been exclusively gay and monogamous for one and a half years prior to his illness. He had never used alcohol and did not smoke. He had occassionally used drugs in the past but not recently. During much of his illness he was living with a pair of male friends who were not his lovers, and the parents of one of them.

He had a history of enlarged lymph nodes dating back at least five years prior to his diagnosis with AIDS. Three years prior to his initial admission he had hepatitis B. He had been treated for a number of sexually transmitted diseases, including gonorrhea, over the preceding several years.

In late February, 1985, George was seen for a febrile illness with upper respiratory symptoms. His symptoms seemed to wax and wane over five to six subsequent outpatient visits. By late May he was complaining of considerable shortness of breath along with a dry cough. The results of a chest x-ray were normal. A gallium lung scan to look for pneumocystis was positive, and a follow-up bronchoscopy was arranged at that time. The bronchoscopy was diagnostic for Pneumocystis carinii pneumonia. He was begun on Septra, to which he had a severe allergic reaction, including fever, rash, and a markedly decreased white blood cell count. He was then treated with pentamidine intraveneously with good response. During this time he was hospitalized for approximately 12 days.

During this hospitalization he was put in contact with the Department of Social Services, with which he had many subsequent contacts. George was also enrolled in a support group in the Psychiatry Department, with multiple visits. He was treated for a variety of complications, including oral yeast infection and several skin infections. He made a total of 29 outpatient visits during the course of his illness following the diagnosis of AIDS.

Most of this time he was able to continue working. During this period he visited his family in the East. He was not allowed in the home of his sister and in his parents' home was required to eat off paper plates.

In early October, 1986 he came down again with fever and shortness of breath. He was hospitalized, this time for 14

days, and treated with intravenous pentamidine for a recurrence of pneumocystis pneumonia. He showed considerable improvement; however, the planned three weeks of therapy had to be discontinued because of a fall of his white blood cell count. By this time he was beginning to develop altered mentation and began to manifest the form of dementia commonly seen in patients with AIDS. He was discharged, and in spite of the fact that he was extremely weak and showing progressive dementia, he was very well cared for by his close friends. He had already arranged for a Durable Power of Attorney and for health care with one of his friends who was able then to make decisions regarding further care. At this point, home care services were instituted and regular nurse visits made. A CT scan was planned but because of his overall deterioration, it was determined that there would be no further active treatment. A feeding tube was inserted to facilitate his nutrition but this was unsuccessful.

His condition rapidly deteriorated and he was hospitalized for terminal care. Based on his oft-stated requests and upon direction of the individual having Power of Attorney, no therapy was undertaken and he quietly expired after three hospital days.

Case history #3.

Carol (not her real name), 21, had a very rare blood disease involving deficits in clotting mechanisms which required her to have close medical supervision throughout her life. At age sixteen, she had received several units of blood in connection with dental surgery. The year prior to her diagnosis of AIDS, she had been ill several times with non-specific generalized symtoms. In June, 1985 Carol's symptoms increased in severity and included shortness of breath, a persistent cough, weight loss, increased weakness, and night sweats. She was hospitalized in July, and was diagnosed as having Pneumocystis carinii pneumonia (PCP).

Carol and her husband Dave (not his real name) had been married for two years. Dave, 24, was employed as an assistant manager at a local resturant. Carol also worked, but gradually over the previous year she became unable to maintain steady employment because of her increasing disability. As a manager, Dave was expected to put in 12-hour days, five to six days per week. After Carol was diagnosed with AIDS, Dave was terminated from his job. The explanation given was the concern about his wife's diagnosis and his potential inability to continue to work the hours required for his job.

Due to the loss of Dave's job, Carol and Dave were forced to give up their apartment and move in with Carol's parents. The lack of employment and health insurance also forced Carol and Dave to file for public assistance. Their eligibility worker informed them about the Aris Project. After Carol's

discharge from the hospital, Carol, Dave, Carol's mother and one sister began to regularly attend the Aris Tuesday night support group meetings. Carol and Dave requested and received individual counselors.

The impact of Carol's illness upon Dave, his family, and Carol's family was overwhelming. The perceived need for secrecy about the diagnosis of AIDS was felt by every member of Carol and Dave's families, and it severely restricted the couple's support network. The psychological scars will remain forever. The volunteers at the Aris Project became Carol and Dave's extended emotional support family.

Carol was hospitalized at least once a month from July through December, 1985 with exacerbations of her illness. In early 1986, she was diagnosed with toxoplasmosis without apparent neurological deficits. Carol died at the end of May, 1986. At the time of her death she had been unable to walk for several months due to neuropathy, had lost approximately seventy pounds, and was unable to perform the activities required of daily living.

3. INTRODUCTION:

At the Board of Supervisors' meeting of January 14, 1986, representatives from the Bay Area Municipal Elections Committee (BAYMEC) presented a proposal concerning AIDS education and counseling services (see attachment #1). Included in the proposal was a request for the establishment of a Board of Supervisors' Task Force on AIDS. In a February 11 response to BAYMEC's request, County staff recommended to the Board that the Task Force be formed (see attachment #2). In the opinion of County staff, such a task force should develop recommendations to 1) increase community awareness of AIDS; 2) ensure that all aspects of the AIDS problem are examined; and 3) stimulate practical, broad-based responses to the problems. A resolution establishing the Task Force was adopted and Board Chairperson Susanne Wilson appointed Ken Yeager as Chairman of the Task Force.

Representatives from BAYMEC met with the Health Department to decide membership of the Task Force. Membership was drawn from groups representing the community, health care providers, universities, and private industry. The first meeting of the Task Force was held April 17.

Regular monthly meetings followed. The Task Force was updated on activities of the County's inter-departmental AIDS Committee, and the Santa Clara County Medical Society's AIDS Task Force. Statistics and information were requested from various agencies and discussions were held on services available to AIDS patients. Among other activities, the Task Force assisted in the development of a handbook specifying a policy for county employees on AIDS, investigated the Sheriff's Department Medical Unit's policy on AIDS, and reviewed the need and potential provisions of an ordinance outlawing discrimination against people with AIDS/ARC or suspected of having AIDS/ARC.

Late in the year, the Task Force broke into committees to research and write various portions of this report. The following is the result of our work.

Dr. Kenneth Kizer, Director of the California Department of Health, said, "AIDS is rapidly emerging as the worst infectious disease epidemic of this century and probably will eventually rank as one of the worst epidemics of all time." We hope the Board of Supervisors will adopt our recommendations and use every available means to minimize the devastating impact that AIDS is having on our County.

4. CASE PROJECTION, MEDICAL COST AND MEDICAL NEEDS:

Impact of AIDS on Medicine in Santa Clara County, 1987-1991:

We are now feeling the initial wave of what will be the worst epidemic ever experienced by the medical professions in the County. The Federal Centers for Disease Control (CDC) projects up to 270,000 cases in the U.S. by 1991(1). It is estimated that in 1991 56,000 Americans will die of AIDS, more American deaths than occurred in the Vietnam War(2).

Estimates of cases, expenses, hospital days, etc. are subject to many possible variables, some of which can only be grossly estimated. In this report we have used the most accurate data available to us. Our projections are in the mid-range where only ranges are available. We have cross-checked against estimates available from other sources, as is indicated largely in the footnotes. As data becomes more complete, the estimates can be revised by insertion of new variables.

Estimates of AIDS cases:

The County of Santa Clara had 183 cases as of 1/16/87 (S.C.County Health Dept.). Estimates of the projected annual rate of increase are 1.5- to 2-fold. This has resulted in estimates from various sources for 1991 in Santa Clara County of 1566-5760 cases. For the three preceding years the annual increase has been 2-fold. Factors that influence the projection include not only estimates of the rate of infection by the etiologic agent, human immunodeficiency virus (HIV), but the rates of conversion from subclinical infection to AIDS, movement of patients into and out of the County (e.g., to seek medical care here vs. elsewhere), and other factors. Heterosexual transmission is now a significant factor. The definition of AIDS is expanding, and the following numbers may be low for that reason. For this report, we have used an estimate of approximately 1.8-fold for the annual rate of increase. This results in a projection of accumulated reported AIDS cases in the County as follows:

1987	324
1988	583
1989	1,049
1990	1,888
1991	3,398

Estimates of the life expectancy of AIDS patients from time of diagnosis to death range from nine months to three years. This will be influenced by the success of currently experimental therapies. We have used for our projections a life expectancy of two years. This results in the following estimate of living AIDS patients in the County requiring medical care:

1987	185
1988	319
1989	564
1990	1,016
1991	1,827

Estimates of ARC Cases:

Current data suggests that there are 3-10 ARC (AIDS-related complex) patients per AIDS patient(3). ARC itself is a fatal condition only in that it progresses in many instances to AIDS (estimates of up to 70% over five years). Estimates of life expectancy of these patients are unavailable. ARC is not a reportable disease. We have used an estimate of 6.5 ARC patients per AIDS patient. The approximate number of ARC patients estimated in this County is thus:

1987	2,106
1988	3,790
1989	6,819
1990	12,272
1991	22,087

These estimates of AIDS and ARC patients do not include asymptomatic persons infected with HIV. Current estimates are that there are 75 HIV-infected persons per AIDS patient (300,000 Californians in 1986)(4).

Estimate of Medical Costs:

The cost of hospitalization for AIDS patients is the largest medical cost. Statistics available from other areas indicate that AIDS patients, on average, require 2-3 hospitalizations per year. Estimates of the number of days of hospitalization vary from 69 days lifetime(5) to more than 150 days lifetime(3). The amount of hospitalization required is subject to many variables, including availability of non-hospital care for sick or dying patients, success of experimental therapies in preventing the secondary complications (opportunistic infections and cancers) of AIDS that necessitate hospitalization, and other variables. In addition to hospital days, AIDS patients are estimated to require 20 out-patient visits per year(6). We estimate, for purposes of this report that ARC patients require the same amount of outpatient care and no hospital care; we do know, however, that ARC patients are hospitalized for diagnostic work-up and therapy, but hospitalization data is not available for them.

For these calculations, we estimate an average of two hospital stays per year for the projected two year life span(7). Data on hospital charges in Santa Clara County for AIDS show an average charge per stay of $17,718 for the first half of 1986(8). This excludes physician fees. The Hospital Conference reports a declining length of stay per patient for each quarter. The average length of stay reported for January to March 1985 was 18.2. This stay had declined to 11.5 days in June 1986. AIDS patients require relatively more intensive care unit (ICU) days than the average patient(9). ICU days are more expensive than average hospital days.

To this we have added physician charges in hospital. These patients are complex cases in hospital, with multi-organ involvement with opportunistic infections or cancer, and require attention from several specialists and generalists. We have estimated an average total physician charge of $61 per hospital day(10).

Using 1986 actual charges for hospitalization, estimates of physician fees and assuming a 5% annual inflation estimate, the hospitalization charges per patient per year estimates for the County are:

1987	$38,682
1988	$40,616
1989	$42,647
1990	$44,749
1991	$47,018

For 1987 the charge per hospitalization would be $19,341 per hospitalization(11). Our estimates indicate an AIDS patient would spend 6.3% of his/her life in a hospital from time of diagnosis(12). The estimated lifetime hospitalization cost for a new AIDS patient alive in 1987-88 is $77,785(13). It should be pointed out that alternatives to hospital care (including nursing homes, hospices for AIDS patients, and extensive supportive community resources) do not presently exist in Santa Clara County.

Using the estimates of living AIDS patients above and the estimated inflation rate, the estimates of annual hospitalization charges are:

	Number of living AIDS patients	
1987	185	$ 7,156,000
1988	319	$12,957,000
1989	564	$24,053,000
1990	1,016	$45,495,000
1991	1,827	$85,902,000

Each outpatient visit has been estimated at $100(14). Given 20 visits per patient per year, the numbers of living AIDS and ARC patients estimated above, and a 5% inflation rate, the estimated annual outpatient medical costs in the County are:

	AIDS	ARC
1987	$ 370,000	$ 4,212,000
1988	$ 670,000	$ 7,959,000
1989	$1,244,000	$15,036,000
1990	$2,352,000	$28,410,000
1991	$4,441,000	$53,693,000

The lifetime medical costs, hospital and outpatient, using these estimates for an AIDS patient living the two years 1987-88 is $82,000(15).

Thus the total estimated annual medical expenditure, hospital and non-hospital, for AIDS and ARC patients in the County is:

1987	$ 11,738,000
1988	$ 21,586,000
1989	$ 40,333,000
1990	$ 76,257,000
1991	$144,036,000(16)

Projections using higher estimates of the number of AIDS patients suggest medical care costs could be as high as $264,960,000 to $432,000,000 in Santa Clara County for AIDS alone in 1991.

Who Will Pay These Costs?

Preliminary data from 1985 in Santa Clara County (Hospital Conference of Santa Clara County) indicated the following hospitalization payment sources (sample size, 72):

30%	HMOs (including Kaiser)
8%	Blue Cross
25%	Other commerical insurance
22%	Medi-Cal
3%	Medicare
1%	Title V
10%	No insurance (includes free, research funds, medically indigent adult (MIA), self pay)

At present, the Medi-Cal program has made AIDS a diagnosis automatically eligible for Medi-Cal support(17).

What will be needed for the medical care of these patients?

Assuming, as above, that 6.3% of the AIDS population will be in the hospital at any one time, the average number of acute care beds used daily for AIDS patients in the county will be:

1987	12
1988	20
1989	36
1990	64
1991	115

Based on current empty private beds in the County, assuming that these beds are not converted to other uses, there would appear to be no need for new construction during this time period. It may be desirable for several of the private hospitals with significant unused bed capacity to develop AIDS wards in their facilities. If Santa Clara Valley Medical Center (SCVMC) continues to run close to capacity, new construction or conversion of other units to inpatient beds may be needed to accommodate its share of the population. Available capacity in private and public hospitals will have to be re-examined in several years to make projections for five years further, to 1996.

Chronic Care Beds:

Approximately 360 beds will be required by 1991, approximately equally divided between skilled nursing facilities and hospice beds. it is quite clear that adequate long-term care facilities could reduce somewhat the need for acute care beds and certainly provide care in the optimal setting. It is quite clear that the bed availability to provide for this need is not present at this time, and a major effort will have to be mounted to provide for this need.

Outpatient Facilities:

It would be desirable to develop AIDS clinics in the private sector where specially trained nurses could do a substantial portion of the monitoring. It is also desirable to develop outpatient facilities for intravenous drug therapy which will be likely necessary in many patients on a weekly basis.

Home Care and Social Services:

It is possible that home health care would be the appropriate level of service for AIDS patients for an average of four weeks during their illness. This would include completion of initial therapy for infections and possibly terminal in-house hospice-type care. This will vary extensively with different groups and with individual patients. Two unknowns which need to be considered are the increasing proportion of AIDS patients who come from the intravenous drug abuse sector, who, having no financial support, will be less likely candidates for any home care, and individuals from the gay community in existing developed and effective home support systems, who, because of previous but presently latent HIV infection, themselves may be the AIDS patients of the early 1990's. Estimates for personnel needs for these areas are as follows: One social worker for every 60-80 patients; one home health nurse for every 60-80 patients. The division between public and private agencies would be subject to the same assumptions and variable discussed elsewhere in this report.

Data on home care costs to AIDS patients is not readily available. Medicare, Medi-Cal, and some private insurance companies pay for intermittent home care services. Most agencies require demonstration of need for ongoing skilled care, such as nursing, before they would pay for supportive or custodial care. Few private insurance policies cover 24-hour care in the home. Charges for intermittent nursing care, home health aides and medical social work may require a minimum of $1,000 per month per patient. Whereas these cases appear to be additional expenses, they would likely be offset by reduction in need for some acute hospital days or chronic care facility expenses. The average duration of home care services following an acute hospitalization may be two months.

Public Hospital Needs:

It is estimated that one-third of the County's AIDS patients may seek care at SCVMC(18). Specific program development to care for SCVMC AIDS patients in the County-owned hospital has been limited to date, and support for programs has been small by comparison with the current needs and in particular with the anticipated needs, and in comparison with a more appropriate level of support and effort expended in some other programs in the County. To date, the Board has budgeted one additional non-physician "clinical coordinator" position to coordinate SCVMC's AIDS programs. Consistent with its mission to provide "state of the art" care to County-responsible and other patients, and its mission as an academic medical center, program development at SCVMC should expand, particularly with specialist physician(s), and should be more centralized. As the Alameda County report states: "Our hospitals must begin utilizing newer experimental treatment protocols in order to best serve the increasing

patient load which will, because of the case fatality rate, be demanding them. In order to do so, additional specially trained staff will have to be put in place." A supervising specialist physician could be responsible for (ibid.) "development of funding proposals and grant writing, preparation of statistical reports, overseeing special studies, and general oversight of the entire program." Physicians leading the AIDS effort must have the background to travel with the advancing edge of medical research, as this is a major area of medical investigation at this time, and for the foreseeable future. Building on existing interest and expertise in opportunistic infections and cancers, specialized protocols, cooperation with Stanford Medical School, and liaison with the gay community, SCVMC could be a local resource for the medical community and complement Stanford University Hospital, particularly in the southern area of the County, in attracting referrals for consultation, protocols or therapy. An AIDS clinic, the first in the County for ongoing care (as distinct form screening or exclusively research purposes) should be supported. The supervising physician described would supervise the aforementioned "clinical coordinator". The coordinator would assist with: statistics, obligatory reporting to public health agencies, and liaison with the Health Department; work with outpatient providers to facilitate hospital admissions and discharge back to outpatient care; coordinate transfers from acute to long term care; coordinate supportive services on discharge and hospice care when needed; assist with experi- mental protocols; work with family and friends of patients; ease the inevitable glitches in the system; triage incoming queries; and assist in educating staff about epidemiological problems these patients may engender.

An SCVMC outreach program as described could also assist other county agencies with medical aspects of their AIDS-related problems, for example the Sheriff's Department. This activity would complement ongoing educational and epidemiological efforts of the County Health Department.

Research Needs:

A long-term answer to the problems posed by AIDS lies in research. Research by county employees and other persons in the county should be encouraged by all levels of government, and by private and corporate support. A relatively small research investment in the prevention and treatment of HIV infection, and of opportunistic infections and cancers, and in more effective health care delivery, testing and education, could have a large impact on the staggering costs of the future medical care of AIDS patients. Most important, it could have an impact on the survival of Santa Clara County residents, and on the suffering of AIDS victims.

Recommendations:

1. The County should expand its resources at Santa Clara Valley Medical Center. This would include development of a specialized AIDS care unit and clinic, as well as recruitment of specially trained staff.

2. The County should address the lack of availability in the community for health care resources needed after discharge from acute hospital care. The priorities are skilled nursing facilities, home health care services, and hospice services.

3. With the guidance of the Hospital Conference and the Medical Society, each hospital should develop policies to facilitate care of AIDS patients. They should be able to identify physicians who are knowledgeable about AIDS treatment and are familiar with community support resources.

4. A long-term answer to the problems posed by AIDS lies in research. Research by county employees and other persons in the county should be encouraged by all levels of government, and by private and corporate support.

Footnotes:

1. Public Health Rep., 101:341, 1986

2. Dr. T. Quin, National Institutes of Health, at Stanford University 1/27/87.

3. AIDS Health Services Program, Robert Wood Johnson Foundation, January 1986.

4. State of California data

5. The Journal of The American Medical Association, 256:3107, 1986

6. Alameda County 5-Year AIDS Plan

7. This is not dissimilar to data from Colorado (Intersci. Conf. on Antimicrob. Agents and Chemotherapy, 1986, abstract #1026), which found AIDS patients had 2.8 (private hospital) to 3.1 (county hospital) hospitalizations from diagnosis to death.

8. Hospital Conference of Santa Clara County, 1986, based on sample size of 72.

9. For example, in Colorado-(7) 7% (private hospitals) to 26% (county hospitals) AIDS hospital days were ICU days.

10. We have used estimates of $150 for the initial admitting physician visit per hospitalization, 6 visits per week in follow-up at $45 per visit, and $300 in consulting physician fees per hospitalization (allowing 1-2 full consultations, 1 follow-up visit, and professional fee for 1 procedure).

11. This is not dissimilar to 1986 estimates by Dr. Phil Lee, University of California, San Francisco, inflation-adjusted to derive 1987 estimates: $9,496 per hospitalization (average duration of stay, 11.7 days) in San Francisco to $21,336 per hospitalization (average stay, 25.4 days) in New York).

12. This is not dissimilar to an estimate used in San Francisco, where they estimate an AIDS patient spends 10% of his/her life in a hospital. (Dr. Merle Sande, Chairman, Dept. of Medicine, San Francisco General Hospital, at seminar at Santa Clara Valley Medical Center on 1/15/87.

13. This is not dissimilar to estimates of lifetime hospitalization costs from other sources(3): $31,973 (San Francisco) or $162,068 (other USA). Alternatives to hospital care are available in San Francisco.

14. Based on $45 for professional fees and $65 for blood tests, cultures, procedures, x-rays, computerized tomography of the skull, etc.

15. By comparison, Dr. Lee's lifetime medical care estimates, inflation-adjusted, are approximately $63,000-$78,750. The differences are not large; possible reasons for the differences have been discussed above. The National Academy of Sciences (10/22/86) estimated lifetime healthcare costs for AIDS patients, inflation-adjusted for 1987-88, are $55,125 to $165,375 each.

16. For comparison, the CDC has estimated that in 1991 direct health care expenditures for AIDS alone will be $8 billion to $16 billion (1.2-2.4% of total U.S. personal health care expenditure). Presently, about 22.2% of all U.S. AIDS cases are in the County (Santa Clara County Health Dept., 5/21/86). Assuming these ratios remain constant through 1991, the County will have 0.58% of all U.S. patients. Using the CDC dollar estimate, the range of estimated costs would be $46,400,000 to $92,800,000 for AIDS alone in the County in 1991. Our comparable projection for AIDS alone in 1991 is $88,704,000. Medical care (and other) expenses in California are believed to be higher than the national average for the U.S.

17. Institute of Health Policy Studies in 1986 indicated the payment sources for AIDS patients as follows:

		Medi-Cal	Medicare	Private Insurance	Self & Other
San Francisco	Municipal Hosp.	64%	2%	17%	17%
	Non-municipal Hosp.	16%	2%	57%	25%
		Medicaid			
New York	Municipal Hosp.	65%	1%	13%	21%
	Non-municipal Hosp.	45%	3%	36%	16%

18. In 1985, when 90 accumlated cases had been reported in Santa Clara County, 28 patients were seen in consultation by the the SCVMC Infectious Disease Service, and others by other services, including Dermatology, Pulmonary, and General Medical Services. Alameda County (5 Year Plan Report) estimates that 30% of its patients will be cared for through county governmental facilities. By 1/16/87, 22% of the AIDS patients reported to the Santa Clara County Health Dept. had been admitted first by SCVMC; the number of SCVMC-responsible patients may be expected to rise above 22% as patients are referred from hospitals unaccustomed to caring for AIDS patients, from Stanford University Hospital for patients exiting special experimental protocols and not receiving ongoing care there, and from any facility if and when the patient's payment sources dry up.

5. EDUCATION NEEDS:

Community education about AIDS must address epidemiology, treatment and prevention. Researchers are working on treatment protocols and a vaccine, but the results are probably years away. Education, though expensive and time consuming, is therefore the only viable approach to prevent the number of AIDS cases from continuing to nearly double annually in the years ahead. Dr. Constance Wofsy of San Francisco General Hospital states that it takes a minimum of five educational exposures (don't understand, don't believe, beginning to believe, it's a problem for others, and they're talking about me!) before an individual has an understanding of AIDS, its causes, epidemiology and prevention.

It is estimated that by the year 1991, there will be 3,398 cases of AIDS in the County. According to James Curran, M.D., at the Center of Disease Control in Atlanta, three-fourths of those who will develop AIDS by 1991 are already infected. Education must be intensified and the media utilized to the fullest if non-infected people are to escape infection. Education must be directed toward all groups in the population regardless of race, ethnic background, gender, religion, age or sexual orientation.

Background:

AIDS education and prevention campaigns began as early as 1983 by a private non-profit organization called the Santa County AIDS/KS Foundation. The Foundation provided education and support services to people with AIDS and to those at risk for AIDS. The Santa Clara County Health Department AIDS Project worked closely with the AIDS/KS Founda- tion to provide educational programs to people at risk for AIDS, and to individuals who would be providing social and health care services to them. In mid-1984 the Foundation's operations were transfered to the Health Department to supplement its AIDS Project.

The Health Department's AIDS Project is part of the County's Public Health Bureau, Medical Services Division. AIDS education is provided through lectures, a telephone hotline, written materials and through radio/TV outreach. Education is also provided by the VD/STD Clinic, the AIDS Screening Clinic, and HIV antibody alternative test sites. As the community's awareness of AIDS has increased, so have requests for services. This has placed great strain on existing programs. Although the programs are respected and well-received, the Health Department is unable to meet the growing needs of the county of almost 1.5 million people due to lack of adequate funding for educational materials and the lack of sufficient staff - essentially three individuals. The Board of Supervisors allocated funds in June, 1986 to hire a Spanish-speaking health educator to provide education and training to the Hispanic population. It is expected that the staff person will be hired soon.

Need for Education:

Action must be taken immediately to curb the increase in the number of individuals infected with the AIDS virus. The Task Force, along with the Health Protection Division and leading AIDS experts have identified the following immediate needs for AIDS education and prevention:

Educational Materials:

A wide variety of educational materials must be developed to reach the entire community. This can be done in creative ways through an extensive AIDS education campaign. More printed materials must be purchased and/or developed. The AIDS Project produced a general informational AIDS pamphlet, "Shedding Light on AIDS," but printing was limited to several thousand copies because of the limited funds from the existing State grant. Request from the community for the pamphlets far exceeded the supply. Also, television and radio promotions must be developed, and handout racks with printed information must be available at hospitals, pharmacies, libraries, medical offices, etc. Educational materials and programs are needed for specified groups, such as, Latinos, Blacks, Asians, American Indians, women, and youth.

Training Materials:

One major focus of AIDS educators should be to train people in the community to assist in AIDS education. This was done, for example, by the Santa Clara County Medical Society and the Health Department in the recent "No on 64" campaign. Training materials should be available immediately so that more community educators will have enough basic AIDS information to educate others. Video tapes, slide shows and training manuals should be developed and distributed to these educators. Presently, the Health Protection's AIDS Project is organizing a core group of public health nurses who have been educated about AIDS issues and resources. These AIDS resource nurses will work throughout the community.

Substance Abuse Education:

Due to the growing evidence that AIDS is increasing among substance abusers, and that AIDS is spreading through this group to the community at large, educational outreach must be provided to this population. Existing programs and materials will have to be modified and adapted to meet the special educational needs of drug and alcohol abusers. Educators, counselors and social workers need training about AIDS to overcome their own fears and anxieties. Education must begin immediately with substance abuse agencies so that they can provide accurate and protective information to their clients. Programs and materials must also be developed to reach individuals at high risk who are not members of any organized group and who are not accessible to educators by traditional means, e.g. workplace settings, schools, clubs, and jail/custodial systems.

Youth Education:

The U.S. Surgeon General, C. Everett Koop, M.D., Sc.D., stated: "Education about AIDS should start in early elementary school . . . Those of us who are parents, educators and community leaders, indeed all adults, cannot disregard this responsibility to educate our young."

Since his statement, requests for AIDS educational materials from the 37 school districts within the county have increased

dramatically. Unfortunately, curriculum and materials for AIDS education are limited in supply or simply unavailable. Resources are desperately needed within the county's educational system to provide training and materials to educators so that they may convey this information to their students.

In addition to school children, educational outreach must continue to be provided and expanded to the youth in non-traditional settings, e.g. Juvenile Hall, detention ranches, Job Corps, street youth, etc.

Women and AIDS:

Women are particularly at risk for AIDS for several reasons. At present, AIDS is generally thought of as a male disease, and many women feel that they are therefore unlikely candidates for the disease. However, a women may not be aware of the history of her sexual partner. If a man has been infected with the AIDS virus through unsafe sex practices or sharing of needles, he may transmit it to her during sex. The amount of the virus carried in semen places women at very high risk. Further, babies born of mothers infected with AIDS are usually infected with the virus. Programs aimed especially at women must be greatly expanded. Family planning clinics must be reached, as well as, OB/GYNs, social groups, etc.

Presently, the Health Department provides clinical services for HIV antibody testing and preliminary screening of people who show signs of infection. With the projected dramatic rise in AIDS and ARC cases, these services will need to be increased. It will be necessary to expand the hours for testing and for discussing test results. Currently, the screening clinic is open only on Tuesday mornings. Staffing of the clinic will need to be increased to meet the growing patient population. Outreach to the changing at-risk populations must be planned and undertaken.

Education in the Workplace:

It is essential that the private sector be a co-participant with the public sector in supporting AIDS education efforts. Although the Health Department's AIDS Program is available to conduct AIDS education seminars in the workplace, the County cannot be expected to bear the full responsiblility alone. Companies must supplement County efforts by soponsoring privately-run seminars and by purchasing AIDS education materials.

By educating workers, employers will help reduce the number of AIDS cases and keep health care costs down. AIDS education will also ease fears when a co-worker is diagnosed with AIDS. This is especially important in light of the recent decision by the California Fair Employment and Housing Commission to ban job discrimination against AIDS victims.

The County of Santa Clara should be commended for its decision to publish and distribute to all County employees an AIDS handbook which discusses AIDS and ways to avoid infection, and outlines the rights of workers who are diagnosed with AIDS. Universities such as Stanford and San Jose State have published or will soon publish similar handbooks. The Business Leadership Task Force of the Bay Area - which includes Bank of America Corp., Chevron Corp., Pacific Telesis, Mervyn's, AT & T, and Wells Fargo - recently sponsored a project to develop extensive guidelines on how to handle AIDS in the workplace.

The local media should also become more active in producing and distributing AIDS information and education materials. As an example of what can be done, the Los Angeles Times recently reporduced and inserted the U.S. Surgeon General's Report on AIDS in a Sunday edition. The San Jose Mercury and other local newspapers should undertake similar creative projects, as should local television and radio stations.

Recommendations:

1. The following projects and personnel should be funded in fiscal year 1987-88:

   a. A wide-range of printed and audio/visual materials. Included should be materials targeted to Latinos, Blacks, Asians, American Indians, women, and youth.

   b. An additional health educator to reach the substance abuse population.

   c. An additional health educator to develop educational programs, do outreach to schools, and to assist in the presentation of educational programs in the schools.

   d. An additional health educator to develop and deliver programs on women's issues.

   e. An AIDS Clinical Nurse Specialist to provide expertise to clinics currently operated by the Santa Clara County Health Department.

2. Additional funds should be allocated in future years to produce and update AIDS educational materials and to hire more personnel.

3. The Board should work in a collabrative manner with external funding sources, groups and organizations to provide the widest possible distribution and development of educational materials

6. SOCIAL SERVICE NEEDS:

The Department of Social Services (DSS), the Public Guardian's Office, and contract agencies such as the ARIS Project provide social services to AIDS/ARC patients. The Public Guardian's Office is involved because of the organic dementia complications suffered by persons with AIDS/ARC and the consequent need these people have for public protection of their assets.

Lack of Education:

It cannot be stressed too strongly that a diagnosis of AIDS or AIDS Related Complex (ARC) is a devastating emotional experience. As a person struggles to deal with the impact of such a diagnosis on his/her personal life, family, friends and loved ones, he/she is thrown into further turmoil when trying to get basic needs met through the social service systems of the County. This is due to the complexity of the systems, the compartmentalization of and the lack of coordination between the systems. The lack of AIDS-related education provided to social service agency employees leads to widespread insensitivity to the particular problems faced by AIDS/ARC clients. Adding to the problem are the cumbersome and complex regulations surrounding the application for general assistance, Medi-Cal, SSI, etc.

While there are 10-12 knowledgeable individuals within the Department of Social Services who could serve AIDS/ARC clients, continuing education is necessary for all personnel who have direct contact with or who supervise people who have direct contact with AIDS/ARC patients.

Access to the System:

For someone who has never dealt with the Department of Social Services, it is a mystery to know what services are available, how to apply for services, and where to seek help. Even after this information is obtained, unless a person specifically requests a social worker, all that will happen is that an eligibility worker will determine the AIDS/ARC clients level of eligibility and process the forms. The client is then left with no social worker assigned to manage the case.

A multi-disciplinary team approach would enhance services and ensure that available services are being utilized as designed. This would lessen the stress levels for AIDS/ARC clients and provide a more healthful and supportive atmosphere in dealing with the many concerns that arise with diagnosis.

Not only must there be coordination of activity between the Department of Social Services and the Public Guardian's Office, but there must be an effort made to reach beyond the agency door to interact with other public agencies, contract agencies, and private community groups.

Findings:

Even though DSS was the first department to establish an intradepartmental committee on AIDS, there is as yet no formalized

process for tracking services to AIDS/ARC clients. One eligibility worker at the main DSS office has provided services through his own inititiative for 15 AIDS/ARC clients in the last 6 months. His peers often refer potential clients to him because of his experience and their own lack of knowledge.

In-Home Support Services (IHSS) provides domestic services. Other services which can be provided through IHSS include services related to domestic service, non-medical personal care services, and various miscellaneous services.

The ARIS Project, an agency which provides services on a contractual basis with the County, began a program offering practical and emotional support to AIDS/ARC clients. During the months of January to December 1986, 78 volunteers provided approximately 1400 hours of in-home support services to an average of 41 clients per month.

Lack of transportation is an increasing problem for AIDS/ARC clients. For example, Medevac Inc. will transport AIDS/ARC clients only in an ambulance. Medevac then charges the client an extra $50 to unnecessarily fumigate the ambulance.

Quarterly in-house educational opportunities on AIDS/ARC have been available at DSS for the past three years, but these are not mandatory for DSS personnel. Attendance has been poor. The Public Guardian's office has not provided AIDS education programs for its employees. Except for the ARIS Project, no other contract agencies provide AIDS education to their employees. This includes the residential drug abuse program as well as agencies dealing with alcohol abuse.

The following three examples demonstrate how initial DSS contact persons often fail to respond to the needs of AIDS/ARC patients.

One individual called DSS District Office and was told that he was not part of their "catchment" area and therefore was not eligible for help at that office. Three months later he contacted the ARIS Project and was appropriately referred to an eligibility worker in the main office of DSS and proper services were rendered.

The husband of a PWA (person with AIDS) wasn't able to cut through all the bureaucratic red tape when he tried to secure Medi-Cal payment for his wife's hospitalization and medical bills. His ARIS Project counselor was able to link him with an eligibility worker at DSS who facilitated the resolution of the situation.

A county resident with neuropsychiatric problems cannot be released from Sequoia Hospital because he has nowhere to go and no one to provide care-giving services to him. The medical staff is not responsible for seeking public guardianship for this client or for coordinating the variety of services needed when he returns home. Therefore, this person remains in the hospital.

Recommendations:

1. An Adult Service Worker Team should be created to assist AIDS/ARC clients with SSI advocacy, health placement services, eligibility requirements, and supportive counseling in each DSS district office. Placement and funding of this team needs further exploration.

2. Mandatory ongoing training in AIDS-related issues should be provided by the Health Protection AIDS Project to all DSS personnel who have direct contact with AIDS/ARC clients. This includes receptionists, eligibility workers, social workers, and their supervisors. Such training should also be required for Public Guardian workers on the same basis.

3. AIDS/ARC patients need to have priority service due to the immediacy of the disease. These priority services would include reserved vouchers for housing, appointment scheduling and in-home support services.

4. Contract agencies need a stipulation in their agreements with the County to provide AIDS training to their personnel, i.e., home-health workers, residential substance abuse program personnel, etc. Further, their agreements should explicitly specify the provision of services to PWAs who are eligible for them.

5. A multidisciplinary approach to delivering services to AIDS/ARC patients should be established. This would involve a team of trained personnel that would coordinate the delivery of comprehensive health care services to the client. The team should be given access to confidential material needed by contract agencies involved with a client in order to facilitate case management.

6. The position of Multidisciplinary Team Coordinator should be created to ensure the efficent delivery of services to AIDS/ARC clients and to avoid duplication of efforts.

7. The Board should refer to the Paratransit Coordinating Council the recommendation that service providers work in cooperation with the ARIS Project to guarantee transportation of AIDS/ARC clients.

7. PSYCHOSOCIAL NEEDS:

AIDS not only severely affects the psychosocial well-being of the individual, but also frequently causes acute and chronic organic neuropsychiatric problems. Common manifestations of psychological stress caused by the diagnosis of AIDS are those behaviors and emotions often observed in individuals facing any life-threatening illness. Isolation frequently becomes an issue when someone is terminally ill; but with the AIDS/ARC patient, isolation may be of greater significance due to the fears and hysteria about the disease itself.

Secondly, supportive social networks of many PWAs are inadequate, thus adding to feelings of isolation and alienation. The majority of PWAs are young and face multiple losses - health, employment, income, relationships, and longevity. Many PWAs have already lost several friends due to AIDS. All these psychological stressors may precipitate mild to severe psychological dysfunction which require a variety of therapeutic interventions.

Severe pyschological problems as well as extremely handicapping neurological disorders are found in 50 to 70 percent of all AIDS/ARC patients. Patients manifesting neurological dysfunctions require caretaking of a different type. With dementia comes the inability to care for oneself; therefore, these patients can not be left unattended.

The most current information available on the psychological impact of this disease indicates a significant underestimation of the emotional impact of an ARC diagnosis and also of the effects of a positive HIV antibody test. Children of AIDS or ARC parents will also require specific therapeutic interventions.

Findings:

The ARIS Project is an emotional support/peer counseling agency dealing with AIDS/ARC patients and their significant others. In March, 1986, the Board of Supervisors approved a $60,000 contract for the ARIS Project for the 1985-86 fiscal year. In June, 1986, an additional $120,000 was approved for the 1986-87 fiscal year. The funds were provided to enable the ARIS Project to expand its services. Currently, the County's contribution accounts for approximately 60 percent of the ARIS operating budget.

From January through December 1986, the ARIS Project provided 6,396 counseling hours to an average of 41 clients per month. During that period, 4,420 client visits were made.

From June 1985 through December 1986, there was a total client intake of 101 people. Of that number, 47 were diagnosised with AIDS, 18 with ARC and 36 were grieving the loss of a loved one to AIDS. As of December 31, 1986, the ARIS Project had 53 active clients, 21 of whom were diagnosed with AIDS, 10 with ARC, and 22 who were grieving. In addition, the Tuesday evening support groups have provided 104 hours of support services to AIDS/ARC patients, 416 hours to grieving individuals, 156 hours to HIV antibody positive persons, and 520 hours to concerned others.

The ARIS Project had trained 106 volunteers as of December 31, 1986 and currently has 87 active support volunteers. The volunteers come from many social, economic, cultural and racial backgrounds. These people are both gay and non-gay; their motives are to help any and all people affected by the virus.

In March, 1986, the Board of Supervisors approved the creation of a Mental Health Committee to work closely with the ARIS Project. Each district mental health office was to have a representative on this committee to ensure the adequacy of Mental Health services in all districts of the County. However, not all district offices have complied. Members of this committee work with the ARIS staff and the ARIS emotional support group leaders.

The Mental Health Department has no systematic way of knowing how many AIDS/ARC clients are being serviced by their personnel. It also applies to those grieving the impact of AIDS/ARC in the lives of their significant others, those who are grieving the death of a significant other, or those traumatized by the eipdemic.

Recommendations:

1. The contract with ARIS Project should be renewed in fiscal year 1987-88. In all probability, an increase in funding in fiscal year 1988-89 will be necessary.

2. County Mental Health should provide in-house training to contract agencies to guarantee that they respond properly to the psychosocial needs of AIDS/ARC clients.

3. All Mental Health district offices should be required to have a representative on the Mental Health Committee for AIDS.

4. A tracking system to measure the impact of AIDS/ARC on Mental Health services should be established.

5. All contract agency contracts should include provisions to provide services to eligible people who have AIDS or ARC.

8. HOUSING NEEDS:

When BAYMEC appeared before the Board of Supervisors in January, 1986, included in its proposals was the allocation of funds to establish a residential care facility for chronically ill AIDS patients. In response by the Director of Public Health, the Board was informed: "Experience in San Francisco and New York suggests that these services will be needed. Last week the Health Department's AIDS Project received 4-5 inquiries about residential care. This is a problem in that the county's residential care spaces are already stretched to the limit, and the fact that AIDS is listed as a communicable disease means that some skilled nursing facilities will not consider accepting AIDS patients. The AIDS Task Force should evaluate these special needs."

The housing needs of PWAs are similar to those with other debilitating diseases. An AIDS/ARC patient's housing needs may change over time from a completely independent living situation to one requiring total caretaking, or it may fluctuate. Some PWAs may need assistance with the activities of daily living and others may not, or they may have family and/or friends providing support. If PWAs develop organic dementia complications, they may require a much more structured environment and closer monitoring. Presently, there are no specific facilities in Santa Clara County designated for PWAs.

As stated in the medical section of this report, approximately 360 beds will be required by 1991, approximately equally divided between skilled nursing facilities and hospice beds. It is quite clear that adequate long-term care facilities could reduce somewhat the need for acute care beds and certainly provide care in the optimal setting. It appears quite clear that the bed availability to provide this need is unavailable at this time, and a major effort will have to be mounted to provide for this need.

Findings:

1. The housing needs of AIDS/ARC patients will increase as previously self-sufficient individuals are no longer able to work and take care of themselves. Many PWAs will require assistance in daily living activities, such as dressing, eating and bathing. The need for assistance will increase as the number of AIDS cases increase.

2. There is no plan to provide home care to PWAs.

3. In cities with increasing numbers of AIDS/ARC cases, there are many reports of eviction by landlords who are afraid of and unknowledgeable about AIDS and its transmissability.

4. People with AIDS/ARC will have need for some or all of the following types of services:

    * Day Center - A non-residential place for leisure activity for people with AIDS/ARC to relieve social isolation.
    * Low Income Housing
    * Independent Living Facilities
    * Residential Care Facilities

* Respite Care - A place where the patient can get proper care, while at the same time giving the regular caretakers a respite from day-to-day responsibilities.
* Hospice Care - For pain management, medical stabilization and terminal care.
* Skilled Nursing Care
* Day Care - a place where neuropsychiatric patients can receive care designed to meet their specific needs.

People providing these services, both County employees and contractors, need to be educated about AIDS/ARC so that they will be able to provide proper service. There is a history in the county of certain non-profit organizations that regularly provide such services denying them to AIDS/ARC patients. County contracts with contractors do not now require that they service people with AIDS/ARC.

5. The increase in the number of AIDS/ARC cases will burden the existing facilities which provide housing assistance. It may become necessary to provide additional facilities in the future. Currently, there are no plans to do so.

Recommendations:

1. The Board should direct the Administration and County Counsel to include language in all contracts to require that service not be denied to individuals with AIDS/ARC when providing the following:

    * Day Center Activities
    * Low Income Housing
    * Independent living Services
    * Residential Care Services
    * Respite Care
    * Hospice Care
    * Skilled Nusing Care
    * Day Care

2. The Board should direct the County Executive to report back within 90 days on the need through 1991 for additional housing facilities and services that may be necessary for people with AIDS/ARC.

9. AIDS POLICIES IN THE JAILS

Background:

The protocol to isolate AIDS, ARC and HIV antibody positive inmates and to take medically unnecessary measures during their incarceration was brought to the attention of a member of our Task Force in early September (see attachment #3 for protocol). On October 16, a front-page article about the protocol appeared in the San Jose Mercury. Because the announced protocol differed from policies in most state and federal prisons (according to national study for the Federal Department of Justice), the Task Force reviewed the rationale for the protocol. The Medical Director of the Sheriff's Department, Dr. Earle Sloan, and the the Assistant Sheriff of the Bureau of Custody, Wes Johnson, made presentations to the Task Force.

From the presentations, the Task Force learned that there was a general panic among the deputies about AIDS. Furthermore, prior to the writing of the protocol the Sheriff's Department did not want to house AIDS, ARC or HIV positive inmates in the jail, but wanted to transfer them to VMC. Because it is very expensive to provide custodial care at VMC for prisoners, this was not a viable solution. The Infection Control Unit at VMC did make available to to the jail physician copies of policies developed at VMC for the hospital (see attachment # 4). These were used in part to develop the Nursing Service's current protocol on AIDS for the Sheriff's Department Medical Units.

Findings:

The Current Protocol:

The Task Force found two major problems with the protocol.

1. No distinction is made between an inmate with symptomatic AIDS or ARC and an inmate who is HIV antibody positive or with AIDS/ARC in remission.

   Inmates with symptomatic AIDS or ARC are, by definition, ill. Their immune system is deficient, which makes them vulnerable to a variety of opportunistic diseases. For this and other health reasons, they require special medical attention. To the knowledge of the Task Force, there have been no cases to-date of a male inmate with AIDS or ARC booked into the county jail. Should such cases occur in the future, the jail physician might advise hospitalization depending on severity of the illness. Because it is unlikely that a symptomatic AIDS or ARC patient would be housed in the jail, the policy is only relevant to HIV antibody positive inmates.

   By being placed in medical isolation, HIV antibody positive inmates are grouped in the same category as inmates whose highly contagious diseases make it impossible for them to participate in such programs as work furlough and trusteeships. In addition, they are subject to regulations designed for inmates with contagious diseases, such as Hepatitis A and measles, and they must speak

through a plastic-wrapped telephone receiver, eat on disposable plates, and have their clothes marked "contaminated."

These procedures are not only medically unnecessary and personally humiliating; they also confuse the distinction between a patient who is HIV antibody positive and one who actually has AIDS or ARC, and furthers the notion that AIDS is casually transmitted. The AIDS virus is very fragile, and can only be transmitted through direct blood-to-blood contact or by certain sexual practices.

It should be noted that the protocol is not applicable to the Women's Detention Facility at Elmwood. The women's jail does not have an isolation ward, only a "sick bay." One woman who requested to be tested for the AIDS antibody was discovered to have ARC. Dr. Sloan asked that a judge dismiss her case. The request was granted. The Task Force believes that the jail physician and the Sheriff, upon reviewing the current protocol, should issue an appropriate protocol for the Women's Detention Center.

As stated in the current protocol, one of its purposes is to "provide an optimal level of care to immunocompromised patients." However, people who are HIV antibody positive are not immunocompromised. While it is important to use infection control procedures when dealing with the blood or body fluids of any individual, there is no medically supportive reason to treat an HIV antibody positive inmate differently from anyone else in the general population. Correctly, the protocol does not make reference to a physician's need to advise hospitalization for HIV antibody positive inmates.

In testimony before the Task Force, speakers stated that the purpose of the protocol is to protect the inmate. It seems, however, that the protocol's purpose is to (falsely) protect the jail staff and other inmates. This makes the patient a "villain." Such a philosophy is clearly wrong.

2. The Nursing Service's protocol differs from that of VMC Infection Control's protocol.

The VMC Infection Control Manual does not call for isolation of AIDS, ARC or HIV antibody positive patients It does state that a private room should be used until assessment of the patient indicates lesser precautions are adequate. Respiratory or Strict Isolation can be required if appropriate. A cooperative, non-coughing patient without diarrhea may have a roommate if the roommate is not an immunocompromised host and does not have infection. Masks, gloves, gowns, and/or protective eyewear should be worn where there is close, sustained contact with a patient with any disease transmissible by blood or other body fluids.

An HIV antibody positive inmate who is not otherwise ill does not need medical attention. The chance of a sheriff's deputy coming into contact with the inmate's blood or other body fluids is no greater than with any other inmate.

Dr. David Stevens, head of the Infection Control Unit at VMC and a member of the Task Force, stated that the AIDS policy for the jail "does not represent what we do in our institution. We would not recommend and never recommended such a policy " (see attachment #5).

Testing:

Testing of inmates for the HIV antibody is done through the Health Department and is strictly voluntary, as is mandated by California law. Dr. Sloan counsels all those requesting the test or information about its implications. Approximately 50 percent of the inmates who initially request the HIV antibody test change their minds. The Task Force supports this procedure. After one year, 24 inmates have been tested, four of whom were found to be HIV antibody positive. Dr. Sloan ordered each of them to medical isolation.

Although test results are confidential under California law, as soon as an inmate is placed in medical isolation, he is assumed to have AIDS by both the jail staff and the prison population. In practice, therefore, there is no confidentiality.

High Risk Behavior:

From the presentations, the Task Force learned that IV drug abuse is prevalent. This is evident by the large confiscations of drug paraphernalia found during weekly shakedowns. Tattooing with unclean needles is a common practice. Although we know that forced homosexual rape occurs, no information was provided on its frequency.

From the information obtained by the Task Force, it appears that the entire jail population is at risk for exposure to the AIDS virus. Yet, AIDS education is not available to inmates. Condoms are considered contraband by the Sheriff's Department and therefore unavailable. Although inmates are in constant jeopardy of exposure to the AIDS virus and of potentially infecting others when released, no preventative measures have been taken.

Education:

AIDS education is not mandatory, yet information can and should be available during the booking process and during incarceration. While the Task Force understands the difficulties inherent in educating people who have little regard for society's rules and regulations, we do not believe it is impossible to convey the dangers of high-risk behavior to the jail population. There is no other alternative. The Sheriff's Department must formulate an effective AIDS education program for its inmates or else take responsibility for the fiscal, medical and moral consequences of the needless infection of an entire group of people with AIDS. Education of prisoners also provides an opportunity to reach an at-risk segment of the population which is difficult to reach on the streets and likely to spread the disease into the community at-large.

San Francisco, which like Santa Cruz County, does not isolate its

prisoners, has set up an AIDS education program. Santa Clara County could learn much from San Francisco's experiences as well as from other prison systems with similar programs.

Staff Training:

The Task Force was greatly concerned when Assistant Sheriff Wes Johnson stated that the jail staff was not being educated about AIDS. He said the reason for this was that no one in the state was qualified to conduct such a training. It was pointed out to Mr. Johnson by the Task Force members that the County Health Department provided training to deputies last year, and is willing to do so again this year. According to Public Health employees, jail administrative staff have not participated in the training program.

The New Jail:

Construction of the new jail is expected to be completed in December, 1987. Wes Johnson stated that people with AIDS will be housed in single cells in the medical unit.

If, in the future, a person with AIDS or ARC is booked into the main jail, it might be appropriate to house him in the medical ward. However, for reasons previously stated in this report, an HIV antibody positive inmate should not be placed in the ward. We have concerns that this will occur.

The Task Force has learned from the County's program manager for the Elmwood Master Plan that Dr. Sloan has proposed single-cell availability for AIDS inmates and a possible AIDS housing module as part of the Master Plan (see attachment #6). A separate module would be medically unnecessary, poor use of valuable space, and a waste of taxpayers' money. We strongly oppose such a plan.

Recommendations:

1. The policy to put HIV antibody positive inmates in maximum-security medical isolation should be discontinued.

2. HIV antibody positive inmates should be granted the same privileges as other inmates, such as, full participation in work furlough programs and trusteeships.

3. Ongoing AIDS education should be made available to all inmates, and be mandated for male and female inmates who have been sentenced. A procedure should be developed that assures AIDS education at the earliest possible time.

4. The Sheriff should report to the Board on his efforts to eliminate IV drug abuse, tattooing and rape in the jails.

5. An appropriate AIDS protocol should be issued for the Women's Detention Center.

6. Condoms should be made available to inmates.

7. Plans to house HIV antibody positive inmates in the isolation ward of the new jail should be overturned.

8. A special AIDS module should not be part of the Elmwood Master Plan.

9. Education of Sheriff's deputies on AIDS should be continued by the County Health Department's AIDS Project. Jail administrative staff also should be educated on AIDS.

10. The Sheriff should obtain ongoing input from experts knowledgeable in Infection Control to develop AIDS programs and write AIDS policies.

11. The County Executive's Office should review procedures in all County correctional institutions to determine if policies regarding persons with AIDS, ARC or who are HIV antibody positive are medically appropriate and necessary.

10. COUNTY LEGISLATION:

Discrimination in Santa Clara County:

Because AIDS is not spread by casual contact, a person with AIDS or ARC poses no health threat to the general public. However, in Santa Clara County there are reports that certain services have been unnecessarily denied to patients with AIDS. Based on County Department of Health projections, the number of AIDS cases in Santa Clara County will increase almost geometrically over the next five years. With increasing numbers of individuals with AIDS and ARC, increased cases of discrimination are anticipated.

The Task Force does not know the full extent of current discrimination. We do know that certain publicly-supported groups turn away AIDS patients. In the past, the Center For Living With Dying, a United Way agency, refused to provide services to AIDS patients. To our knowledge, all long-term care facilities, i.e., nursing homes and convalescent hospitals, have not allowed admission to AIDS patients. While paramedic services appear to be available, AIDS patients are charged an additional fee of $50 to "sterilize" the ambulance after usage. Similar fees are not applied to other patients. The Sheriff's Department routinely isolates individuals testing HIV antibody positive. Families and friends of AIDS patients also face discrimination. Helen Miramontes, President of the California Nurses Association and a member of the Task Force, reported a case in Santa Clara County where the fear of AIDS led one employer to fire the husband of an AIDS patient.

The State and Other Cities:

As evidenced by reports in San Francisco, Los Angeles, New York and other cities, AIDS discrimination exists in employment, housing and other areas. As the number of cases continues to increase, we are seeing a concomitant rise in the number of AIDS discrimination complaints. This is the situation in San Francisco where the number of complaints is expected to double this year.

In California, several cities have recognized the necessity of enacting AIDS anti-discrimination ordinances to protect their residents. They include Los Angeles, San Francisco, West Hollywood, Berkeley and Oakland. Bay Area companies which have non-discrimination policies include Apple Computers, Tandem Computers, Bank of America, Levi Strauss & Co., Chevron Corporation, Pacific Telesis, and Wells Fargo.

Legal protection from the State is unlikely to be forthcoming. Although the State Legislature last year passed two bills which would have classified AIDS as a disability, thus covering it under current anti-discrimination laws, Governor Deukmejian vetoed them. Legislation has been introduced again this year, but the Governor has made no indication that he will support it. It regard to the recent decision by the Fair Housing and Employment Commission to ban job discrimination against AIDS patients, we do not know what the result would be should someone challenge the ruling in the courts.

A Proposed Ordinance:

When the County Board of Supervisors established the AIDS Community Task Force, they demonstrated their desire to prepare the county for all aspects relating to the epidemic. Discrimination based on AIDS is one such aspect. Just as the Board of Supervisors has always taken action when discrimination occurred against any group of people, so should the Board do so now for people with AIDS and ARC and their loved ones.

The County Counsel's Office, in response to Supervisor Mc Kenna's request (see attachment # 7), issued an opinion on the extent of the County's jurisdiction to adopt an AIDS anti-discrimination ordinance. Although the ordinance would be effective only in the unincorporated areas of the county, it may indirectly produce desired results county-wide. Not only would it send a message to all residents and municipalities, but also encourage businesses that operate in the unincorporated area to apply the ordinance to their businesses located in municipalities. The Task Force believes that a County AIDS non-discrimination ordinance should address the following areas:

* Housing
* Employment
* Access to medical services
* Access to paramedical services
* Banking and lending institutions
* HIV testing

Adoption of an AIDS anti-discrimination ordinance will be in keeping with the Board of Supervisors' long-established record of non-discrimination. It will send a strong signal to cities in the county that such an ordinance is necessary within their jurisdictions. Following adoption, the Task Force would urge the County to contact the mayors and request their cities adopt similar ordinances.

Recommendation:

1. The Board of Supervisors adopt an AIDS anti-discrimination ordinance affecting the areas of employment, housing, access to medical services, access to paramedical services, banking and lending institutions, and HIV testing.

11. FUTURE OF THE AIDS COMMUNITY TASK FORCE:

The resolution which established the Task Force stated that when submitting its report, the Task Force also would make recommendations on its future membership and continued activities. We are of the opinion that the Task Force has served an important function and can continue to do so in the future.

Therefore, we believe that the Task Force should continue in existence another year. Our responsibilities should include overseeing the implementation of the recommendations, conducting meetings, and issuing reports to the Board of Supervisors on an as-needed basis. We recognize the need for public input regarding the AIDS epidemic, and believe that the Board of Supervisors should co-sponsor such a hearing with the Task Force.

We also believe that the membership of the Task Force should be expanded to include minority representation. In addition, a representative from the business community should be appointed to replace Mike Morris, formerly of ROLM Corp., who resigned because of time constraints. Also, Local 715 is encouraged to fill their vacant position on the Task Force.

Recommendation:

1. The existence of the AIDS Community Task Force should be extended for another year.

2. The Board of Supervisors should co-sponsor a public hearing on AIDS with the Task Force.

# # #

Attachment (a)

BAYMEC

Bay Area
Municipal
Elections
Committee

P.O. Box 90070
San Jose, CA 95109
(408) 297-1024

Proposal to the Board of Supervisors To Provide Adequate Service to AIDS Patients In Santa Clara County

1. Allocate $60,000 in Mental Health contracts to the ARIS Project to provide staff, counseling, and services; allocate $120,000 in FY 86-87.

2. Allocate funds to establish a residental care facility for chronically ill AIDS patients.

3. Establish a program to educate county employees who may work with AIDS patients, including deputy sheriffs, probation officers, social workers, and health department staff.

4. Create a Board sponsored AIDS Task Force to assess needs and develop a comprehensive AIDS program for the county.

5. Allocate additional funds for education and educational material targeted to high-risks groups.

6. Increase staff levels of the AIDS project in order to provide more pro-active outreach to community groups.

7. Increase educational outreach to doctors, nurses and other health professionals to ensure high quality care in our county.

8. Publicize the county's ability to care for AIDS patients at VMC.

9. Direct the Mental Health Department to establish a working relationship with the ARIS Project to coordinate mental and emotional support for AIDS patients.

County of Santa Clara
California

Health Department
2220 Moorpark Avenue
San Jose, California 95128

Attachment (b)

Prepared By: J.M. Mason
Reviewed By: D.B. Alvarez
Submitted By: J.K. Bartholet

TO: Sally Reed
County Executive

FROM: J. Kennedy Bartholet
Health Services Administrator

DATE: February 3, 1986

SUBJECT: Acceptance of Reports Concerning BAYMEC Proposals for AIDS Education and Counseling Services.

RECOMMENDED ACTION

It is requested that the attached reports concerning BAYMEC Proposals for AIDS education and counseling services be submitted to the Board of Supervisors.

REASON FOR REQUEST AND BACKGROUND

At the Board of Supervisors meeting of January 7, 1986, the Board referred to staff proposals from BAYMEC Concerning AIDS education and counseling services. The attached report is the staff response to the Board's referral.

FISCAL IMPLICATIONS:

Up to $60,000 may be required in 1985-86 for contract development and start up services. The cost for 1986-87 is unknown at this time.

STEPS FOLLOWING APPROVAL

Responsible Party		
Health Department	Hire Consultant to develop a proposed contract including scope of work.	February 1986
	Submit proposed contract to Board of Supervisors	April 1, 1986

County of Santa Clara
California

Health Department
2220 Moorpark Avenue
San Jose, California 95128

TO: Sally Reed, County Executive

FROM: Delia B. Alvarez, Director of Public Health

DATE: February 3, 1986

SUBJECT: Response to BAYMEC Proposals

On January 29, 1986 a meeting was held to discuss the BAYMEC proposals. Those attending the meeting included:

Steven Coray, M.D., Public Health
Bernadette De Armond, M.D., Public Health
Kay Anderson, Office of Budget
Ken Yeager, BAYMEC
Ron Taylor, BAYMEC/ARIS

ARIS STATUS REPORT

Ron Taylor offered the following information about current ARIS programs: He reported that ARIS has already set up its Board of Trustees and arranged for legal counsel and bookeeping. They have applied to the IRS for non-profit status but expect that the clearance will take several weeks. They are exploring options for insurance coverage from the firm that insures the SHANTI project in San Francisco. (SHANTI is the AIDS support program on which ARIS is modeled.)

ARIS has enlisted the support of many local volunteers and ARIS has provided training to these volunteers with the help of the SHANTI group. They now have several people at ARIS who can also provide this training. ARIS has already provided 23 people with AIDS or AIDS related conditions with one-to-one support. They anticipate requests from an additional group of 40-50 people over the next year.

ARIS has provided some housing to people with AIDS through the assistance of volunteers who donate space within their own homes. They have developed links with home health care facilities as well.

ARIS recognizes the need for the assistance of mental health professionals in working with selected clients. They have already found that their support services are not sufficient for clients with severe depression, or neuropsychiatric problems associated with AIDS.

The group then discussed the proposals that BAYMEC had presented to the County Board of Supervisors on January 14, 1986.

1. Request For Funds For Mental Health Contracts For ARIS in 1985-86 and 86-87.

It was recommended that the Public Health Bureau offer a short-term service agreement in which the county would hire a consultant who would work with ARIS to develop the contract for ARIS services. With the assistance of this consultant, ARIS would develop a contract for services that would be acceptable to the Health Department and to the county Executive. The contract would outline the scope of work to be provided, identify the auditing procedures, and define the budget.

2. Residential Care Services

Experience in San Francisco and New York suggest that these services will be needed. Last week the Health Department AIDS Project received 4-5 inquires about residential care. This is a problem in that the county's residential care spaces are already stretched to the limit; and the fact that AIDS is listed as a communicable disease means that some skilled nursing facilities will not consider accepting AIDS patients. The AIDS Task Force should evaluate these special needs.

3. Education Programs for County Employees

The Public Health Bureau's AIDS Education Project is working to meet these needs for example the following programs have been presented.

Deputy Sheriffs - Mandatory, continuing programs for all staff

Social Workers - The first program was held in 1984, programs have been offered to many offices; in some cases attendance was mandatory.

Health Department - We have met with PHNs and Environmental Health, Methodone staff, Alcohol staff, and some staff members in Mental Health.

Police Department - Ongoing program with San Jose Plice with weekly programs since Sept., '85; also programs have been presented to the local CHP staffs.

Fire Departments - Several mandatory education programs have been presented in Santa Clara, San Jose, Morgan Hill, and several others have been scheduled.

Institution Staffs - Parole officers in Elmwood, Juvenile Hall, and the Boy's Ranch.

4. AIDS Task Force

A Community Task Force could be beneficial in several ways:

a. To increase community awareness of AIDS
b. To insure that all aspects of the AIDS problem are examined.
c. To stimulate practical, broad based responses to problems.

The Task Force should probably include such groups as;
Public Health

Community groups with special concerns about AIDS, e.g. ARIS, BAYMEC

Health Care Providers (e.g. Medical Society and hospital council and home health care or residential care.

Mental Health

Legal counsel

University representatives

Private industry representatives to discuss work related problems.

A County Committee has been formed to discuss AIDS related issues. The first meeting was held on January 24, 1986. Representatives from Public Health, Mental Health, DSS. DA, Drug Abuse, Alcohol, Juvenile Hall, Adult and Juvenile Probation, Valley Medical Center, Public Defenders, Sheriff's Department and County Exexutive's office were present. The needs of each group were outlined and further working sessions were planned.

5. Additional Funds For Education And Education Materials

Some of these needs may be met through the regional program with ABAG. Public Health will explore whether increased State funds may be available next year. The educational needs are also being reviewed as part of the County budget process for FY 1987.

6. Increase staff levels of AIDS project

Plans to augment the staffing of the county AIDS Project are under discussion as part of the budget planning process for FY 1987.

7. Increase educational outreach to doctors, nurses, etc.

Each hospital has provided AIDS education to their staffs and most continue to update these programs regularly. The AIDS Education project has provided spreakers for many of these programs. The new county Medical Society Task Force will help enhance these programs.

8. Publicize VMC services

At present people with AIDS have been cared for in almost all of the local hospitals. VMC provides care to inpatients and outpatients with AIDS or with AIDS related disorders but they do not serve all people with AIDS. In the 1980's the site of many people's hospital care is determined by their employers insurance coverage; AIDS is no exception. Certainly if VMC or another site were set up as a special AIDS diagnostic program it would serve as an important addition to existing services.

9. Direct Mental Health to establish a working relationship with ARIS

Representatives from Mental Health have met directly with ARIS to discuss plans for needed services. The assistance of the Mental Health Bureau will also be needed in providing crisis intervention, providing back-up to the ARIS counsellors, and in auditing the service component of the ARIS contract.

DBA:BDA:vlc

cc: Ken Bartholet, Health Services Administrator
Steve Coray, MD, Chief of Health Protection/Health Officer

January 30, 1986

TO: Ken Bartholet

FROM: Ron Christensen

SUBJECT: Role of the Mental Health Bureau for AIDS Patients

The role of the Mental Health Bureau in providing services to persons with AIDS, or persons concerned about AIDS will be as follows:

-- Psychiatric Inpatient Services: Will continue to provide care for persons with AIDS just as they would to any other member of the community, as long as they meet admissions criteria.

-- Outpatient Services: Plans for the development of outpatient treatment services for AIDS clients and their families are in the process of being developed, with the goal being to develop a network of therapists located throughout the County. It is hoped that this service can be available by April 1, 1986.

In addition to the above services, it is the goal of the Mental Health Bureau to identify a liaison person from the staff of its outpatient program, to act in a liaison capacity between the Mental Health Bureau and the ARIS PROJECT.

RC:th

ACQUIRED IMMUNE DEFICIENCY DISEASE (AIDS) AND AIDS RELATED CONDITION (ARC)

I. PROTOCOL

Any AIDS or ARC patient or a patient with a positive HTLV III antibody shall be identified where possible by the physician/nurse during the intake screening process or during the course of incarceration based upon Center for Disease Control (CDC) Guidelines (Atlanta, GA) for the diagnosis of AIDS/ARC.

II. PURPOSE

A. To provide an optimal level of care to immunocompromised patients.

B. To provide guidelines for the health protection of other inmates, visitors and staff.

III. REFERENCE

SCVMC Infection Control Manual and Morbidity and Mortality Weekly Report (MMWR)

IV. PROCESS

A. GUIDELINES FOR CARE OF PATIENTS

1. Any patient identified as having AIDS or ARC or a patient with a postitive HTLV III antibody shall be placed in segregated housing (Main Jail or WDF) when such housing is advised by the physician or designee.

2. In order to maintain confidentiality, such segregated housing shall be labelled, "For Infection Control." This labelling shall also be used for any other infectious diseases which may require isolation such as hepatitis A, measles, etc.

3. The physician may advise hospitalization for any AIDS/ARC patient depending on serverity of the illness. The patient should be counseled about precautions to minimize his/her risk of infecting others.

B. GUIDELINES FOR STAFF (See VMC Infection Control Manual Guidelines, #752 and 710).

C. GUIDELINES FOR DEPUTIES

1. **Housing** The patient is assigned to segregated, medically approved housing marked, "For Infection Control".

2. **Gown** Required if soiling of clothing with blood or body fluids is likely.

3. **Mask** Wear a mask for close, sustained contact of a compromised patient (as determined by medical staff) or coughing a inmate.

4. **Gloves** To be used for all direct contact with blood, urine, stool, vomitus, or saliva, (or other body fluids).

C. GUIDELINES FOR DEPUTIES (Continued)

5.	Disposal of wastes	A. Deposit all feces, urine, or other body wastes in the toilet, not in the hand wash sink. B. Linens and trash soiled with blood, feces, urine, or other body fluids must be specially handled using a red bag for trash and a dissolvable interlaundry bag for linens. C. Needles, sharps, syringes are to be disposed of in red puncture proof containers. Do not recap needles.
6.	Handwashing	Wash hands before and after patient contact, even when gloves are worn.
7.	Spillage accidents	If blood or other body secretions are spilled, immediately wipe up spill and wash with Hypochlorite (Chlorox), 1:10 solution. Wear gloves when cleaning up spills.
8.	Cleaning principles	Items soiled with blood or body fluids should be cleaned with a 1:10 solution of chlorox, disposed of or sterilized.
9.	Food trays	Paper, disposable trays and plastic eating utensils are used when patient is in isolation. Use gloves to dispose of these trays and plastic eating utensils.
10.	Inmate Transport	A. The patient should wear a mask when coughing is a significant symptom. B. No special precautions are needed for the deputy.

(The guidelines for Deputies are to be available as instructional handouts - see attachment).

Approved by Maryann Laughlin — Date 12 Dec 86
Assistant Director of Nursing,
Insitutional Medical Units

Approved by Phillip R Dean — Date 12/12/86
Medical Director, SCVMC

Approved by Earle R. Sloan — Date 12/12/86
Medical Director, Sheriff's Department

Approved by Wesley O Wilson — Date 12/15/86
Assistant Sheriff, Bureau of Custody

GUIDELINES FOR DEPUTIES

1.	Housing	The patient is assigned to segregated, medically approved housing marked, "For Infection Control".
2.	Gown	Required if soiling of clothing with blood or body fluids is likely.
3.	Mask	Wear a mask for close, sustained contact of a compromised patient (as determined by medical staff) or coughing inmate.
4.	Gloves	Not for casual contact. To be used for all direct contact with blood, urine, stool, vomitus, or saliva, (or other body fluids).
5.	Disposal of wastes	A. Deposit all feces, urine, or other body wastes in the toilet, not in the hand wash sink. B. Linens and trash soiled with blood, feces, urine, or other body fluids must be specially handled using a red bag for trash and a dissolvable interlaundry bag for linens. C. Needles, sharps, syringes are to be disposed of in red puncture-proof containers. Do not recap needles.
6.	Handwashing	Wash hands before and after patient contact, even when gloves are worn.
7.	Spillage accidents	If blood or other body secretions are spilled, immediately wipe up spill and wash with Hypochlorite (Chlorox), 1:10 solution. Wear gloves when cleaning up spills.
8.	Cleaning principles	Items soiled with blood or body fluids should be cleaned with a 1:10 solution of chlorox, disposed of or sterilized.
9.	Food trays	Paper, disposable trays and plastic eating utensils are used when patient is in isolation. Use gloves to dispose of these trays and plastic eating utensils.
10.	Inmate Transport	A. The patient should wear a mask when coughing is a significant symptom, if recommended by Medical Staff. B. No special precautions are needed for the deputy.

DISEASES TRANSMISSIBLE BY BLOOD AND BODY FLUIDS, E.G., AIDS

Note: See separately policies for Creutzfeld-Jakob disease and hepatitis. See index of disease for leptospirosis and syphilis. These four diseases are also transmissible by blood and body fluids.

I. POLICY

A. Acquired immune deficiency syndrome (AIDS) patients will be defined according to the guidelines of the Center for Disease Control (CDC). Diagnosis will be made by the primary physician.

B. Patients (inpatients and outpatients) diagnosed as AIDS, those who may possibly have AIDS, and those known to be positive for HTLV-III serologically or virologically will be managed under the "Precautions" (see pages 2-4). "Patients who may possibly have AIDS" would include (but not be limited to) patients with thrush, chronic diarrhea, idiopathic thrombocytopenia, generalized adenopathy, unexplained weight loss, prolonged unexplained fever or sweats in persons belonging to groups with apparently increased risk of AIDS (homosexual or bisexual males, IV drug abusers, sex partners of AIDS patients, hemophiliacs), patients being evaluated for AIDS, and patients with Kaposi's sarcoma over age 60 with unknown HTLV-III status.

C. Training of physician and nursing personnel in the recognition, management, treatment and counseling of these patients is the responsibility of the employee's immediate Supervisors/Administrators.

D. Employees associated with the care of these patients who have needle stick injuries must report to the Employee Health Service where ongoing records will be maintained.

II. PRECAUTIONS REQUIRED FOR IN-PATIENT CARE:

A. Private Room. Use private room with private bath (except ICU) until assessment of the patient indicates lesser precautions are adequate. The door may be open unless the patient requires Respiratory or Strict Isolation for an associated disease. A cooperative, noncoughing patient without diarrhea may have a roommate; this roommate should not be an immunocompromised host nor a patient with infection.

B. Door and Chart Labels.

Post green door sign with appropriate items checked as soon as the diagnosis is suspected. A pink "Blood and Body Fluid" label must be put on the metal chart. Medical Records will be placing a pink "Biohazard 752" label on the patient's permanent chart to help identify these patients.

C. Isolation Cart. Order from C.S.R. if soiling likely. If not ordered, gloves and specimen bags must be available.

D. Gown. (Not required for casual contact.) Required if soiling of clothing with blood or body fluids is likely.

Use water-protective barrier gowns when there will be exposure to large volumes of secretions.

E. Mask and Protective Eyewear. (Not required for casual contact.)
   1. Masks should be used for close, sustained contact of a compromised or coughing patient. Mask the coughing patient when he is out of his room.
   2. Protective eyewear should be used in situations where splatter with blood or body fluids is expected.

F. Gloves. (Not required for casual contact.) Use for all direct contact with blood, urine, stool, vomitus, and other body secretions.

G. Disposal of Wastes
   1. Excretion/Secretions - Deposit all feces, urine, other body wastes in the hopper or toilet. Do not empty body secretions in the hand wash sink.
   2. Needles, syringes, or other sharps:
      a. Use red puncture proof container for these items.
      b. Do not cut or recap needles.
   3. Linens and trash soiled with feces, urine, or other body fluids must be handled using red isolation bag for trash and dissolvable inner-laundry bag for linens.

H. Uncooperative or Irresponsible Patients. If the patient is irresponsible, obtain assistance and restrain the patient to avoid accidental exposure to blood and secretions during procedures.

I. Handwashing. Required prior to and after patient contact even when gloves are worn.

J. Spillage Accidents (of blood or other body secretions.)
   1. Immediately wipe up spill, flush and wash with hypochlorite (Chlorox bleach). Use 1:10 solution.
   2. Order Chlorox from Housekeeping and keep it in the isolation cart or in utility room.
   3. Wear gloves when cleaning up spills.

K. Equipment/Supplies.
   1. Equipment such as laryngoscopes and tracheal tubes, lensed instruments which come in contact with blood, secretions, or excretions:
      a. Must be transported to Sterile Processing in isolation bags and labeled with pink blood and body fluid precaution for cleaning.
      b. Must be cleaned and sterilized (ethylene oxide, glutaraldehyde (e.g., Cidex) or autoclaved).
   2. Use disposable supplies when possible. See H. 3. for linen and trash.

L. Housekeeping
   1. Clean bathroom facilities daily.
   2. When patient is discharged, remove bed-side curtains as part of "terminal cleaning" if soiling was likely to have occurred.

M. Laboratory Specimens. Includes tissue, blood, body fluids, secretions, excretions, exudates, swab, aspirations and smears.
   1. Glove to collect the specimen.
   2. Both the specimen container and the requisition slip must be labeled with pink "Blood and Body Fluid" hazard labels.

3. Plastic bags should be used to contain the specimen container to protect personnel from leakage. Containers too large to fit in small bags must be sealed shut with tape and placed in large plastic bags.
4. Requisition slip must be attached to the outside of the bag, never inside the bag. Otherwise it may be impossible to identify the source of a specimen.
5. All employees are expected to treat all blood and body fluids as potentially hazardous and to handle these fluids with care whether labeled or not.

N. Dietary Tray. Special tray not required.

O. Patient Transport. Use precautions necessary to prevent soiling with patients secretions. (See Infection Control Manual for Transportation of Patients in Isolation.)

P. Education/Management/Responsibilities of Directors/Supervisors/Physician.

1. Provide training in the recognition, management, treatment, and counseling of patients for all housestaff and nursing personnel.
2. Avoid assigning care of AIDS patients to pregnant employees. See C.M.V. Infection Control Index 850.
3. Identify the suspected AIDS patient and order the above precautions until consultation or laboratory data is available (when needed).
4. Review each patient's course in a timely manner to discontinue or increase procedure for prevention of disease transmission.
5. Provide disposable resuscitation bags and masks (available at the bedside at all times and when transporting patient) to avoid emergency CPR oral procedure.

Q. Admitting, and Physician Orders.

To avoid stigmatizing a patient, especially one who may have AIDS (and thus requires special precautions), but in whom the diagnosis has not been made, we should not refer to the patient's diagnosis as "AIDS" in any manner of notation which may be accessible to other than hospital staff. This would include admitting slips given to the patient, responses to callers, labels on outside of specimens, labels on outsides of charts, etc. In lieu of the overall term "AIDS" for this group of patients, which is not accurate for all of them, the term "Biohazard Policy #752" (the number of this policy) should be used as an all-inclusive term in notations which may be accessible to other than hospital staff. The pink "blood and body fluid" labels are similarly not specific for AIDS patients (they are also used for possible AIDS patients, HTLV-III positive patients, and patients with other blood-borne diseases), and the green door signs to be used do not say (and do not mean) "AIDS", but have a checklist for the procedures to be followed for that patient in isolation.

III. PRECAUTIONS FOR OUT-PATIENT CARE OR AMBULATORY CARE

AIDS or possible AIDS patients may use common waiting areas and bathroom facilities, since close sustained contact is markedly less direct, with the following precautions:

Minimize direct contact with other severely immunocompromised patients.

See In-Patient Care (pages 2 and 3) for:

Laboratory Specimens (M.)
Equipment/Supplies (K.)
Handwashing (I.)
Director/Supervisor/Physician Responsibilities (P.)
Housekeeping (L.)
Disposal of Wastes (G.)
Spillage Accidents (J.)
Mask and Protective Eyewear (E.)
Gloves (F.)
Needle/Syringe (G. 2.)

David A. Stevens

David A. Stevens, M.D.
Chairman, Infection Control Board

Marilyn S Rider RN 5-14-86

Director of Nursing

35P/IC1

PROCEDURES FOR

DISEASES TRANSMISSIBLE BY BLOOD & BODY FLUIDS, eg. AIDS

I. PURPOSE

A. To provide equipment for Infection Control policy 752.

B. To provide guidelines for cleaning, disinfecting, and sterilizing equipment used for Infection Control Policy # 752.

II PROCEDURE:

A. Private rooms are arranged for by charge nurse of the floor housing a patient on Biohazard Policy 752 Isolation.

B. Door, chart, lab labels are available from Infection Control if not available in floor isolation sign box.

C. Isolation carts are ordered from C.S.R. The doctor should place an order for Biohazard policy # 752 on chart.

D. Gowns are available on isolation carts. Water-protective barrier disposable gowns are ordered from sterile processing / cart staging. Operating room also has a supply of these gowns.

E. Protective eyewear is available on isolation carts and sterile supply carts on each floor. Use goggles during procedures where splashing is expected e.g. bronchoscopy, endoscopy, dialysis.

F. Gloves should be available at bedside or on isolation cart.

G. Isolation bags (red & yellow) are available on isolation cart and from housekeepers.

H. 5.25% sodium hypochlorite is available from housekeeping to clean up spills.
   1. Blood spills on smooth and porous surface should be cleaned with 1 part of the above solution diluted in 9 parts water. This solution should be used within 24 hours.
   2. If cleaning spills on aluminum or metal objects, bleach can be corrosive. In these instances, follow manufacturer's recommendations for cleaning, disinfecting and sterilizing.
   3. Use gloves when cleaning up blood and body fluid spills.

I. Equipment and supplies such as lensed instruments which come in contact with blood or body fluids should be sterilized according to manufacturers recommendation for sterilization. Disposable items are preferred and should be placed in plastic bags and disposed per infectious waste policy. Equipment used by departments should have written procedures for cleaning, disinfecting and sterilizing based on manufacturers recommendations and reviewed by sterile processing.

J. Bedside curtains should be taken down following discontinuation of isolation.

K. Laboratory speciman bags are available on isolation cart and on floor carts. Labels are available from infection control and on carts.

L. Disposable ambu bags and masks are available from sterile processing. If an ambu bag is used and is not disposable, it should be bagged, labeled and sent to sterile processing for sterilization.

M. Patients in Biohazard 752 Isolation are transported per Isolation Procedure, Infection Control Manual page 808.

N. Post-Mortem care - see nursing procedure B-6302-A4 and label body with blood and body fluid precautions.

49/IC3

Santa Clara Valley Medical Center

owned and operated by The County of Santa Clara
affiliated with Stanford University School of Medicine

751 South Bascom Avenue
San Jose, California 95128
(408) 299-5100

Attachment (e)

December 19, 1986

MEMORANDUM

TO: Mr. Ken Yeager

FROM: David A. Stevens, M. D., Chief, Division of Infectious Diseases

As discussed with you, I received the minutes for the 11/6/86 meeting of the AIDS Task Force on 12/17. I am disturbed with what is in those minutes and afraid there could be a misinterpretation. I would appreciate it if the administrative assistant could take care of circulating this memo to those who received the minutes.

Under item 4, paragraph 2, indirectly quoting Dr. Sloan on AIDS policy for the jail, it states,"Infection Control at VMC has developed a 'working policy' which is implemented now until a finished policy can be completed." Although there are several ways that could be interpreted, such as "Infection Control has developed a 'working policy' for VMC which the jail is implementing," what I'm afraid of is that it will be interpreted as "Infection Control has developed a 'working policy' for the jail."

Infection Control at VMC, which I head, has never developed any policy for the jail or Sheriff's Dept. We're not capable of doing so, not being familiar with their needs and facilities, and we do not have the resources. We do, as a matter of trying to help, periodically make available to the jail physicians copies of policies we develop for VMC. If they find them useful, fine; if they wish to use them as their policies at the jail, or adapt or change them for their use (or ignore them), they're welcome to do so. Whatever their policies are, however, are still theirs, and we take no responsibility nor credit for them.

In paragraph 3, it states "The 'working policy' is such that diagnosed AIDS cases and HIV positive individuals are placed in separate housing for the duration of their incarceration. Isolation procedures are handled in the same manner as other communicable diseases (styrofoam plates, cups, plastic silverware, clothes washed in separate bags)." This causes me great consternation because, taken together with the quoted sentence in paragraph 2, it might be interpreted that this set of procedures was something developed by VMC Infection Control. It was not, and does not represent what we do in our own institution. We would not recommend and never have recommended such a policy.

Thanks for your help in clearing up any misinterpretation.

cc: Dr. P. Benaron
Infection Control Nurses, VMC

4.7.2 Mental health administrative services and minimum security interview space will be located in the Central Health Care Facility. Interview rooms for mental health use will also be provided in the medium security housing areas and possibly the minimum housing areas as well.

4.8 Safety cells will be located in only the Intake area, rather than in housing units.

4.9 The County does not see the need for licensing and/or accrediting the Elmwood Medical Facility, nor is there an attempt to do this.

4.10 The County currently has an AIDS policy, which VMC calls "protocol". This protocol provides information for deputies, as well as medical staff, in dealing with inmates who have tested positive (positive antibody test HTLV-III). The protocol does not address housing accommodations for such inmates, who do not require infirmary care.

VMC won't accept the AIDS persons above, because they do not meet the criteria for admission.

Currently the number of inmates are small; three persons on isolation at the present time. Both males and females must be considered, when planning for future housing.

4.11 Dr. Sloan has requested only single cell availability for AIDS persons; possibly the allocation of a housing module in the future. Isolation was also requested, which means no mingling with the general inmate population. It appears that common showers are not a problem in the housing area. Isolation does not negate the need for access to general population services and programs.

4.12 Discussions during the meeting with medical staff on December 11, 1986 pointed to initially locating the AIDS persons in the new Hall of Justice, in an area such as the formerly designated "Female Inpatient and Special Housing" area. The approach to handling AIDS persons is not resolved at this time, though the recommendation is using the HOJ initially.

5.0 CONTINUING ISSUES

5.1 Both a short-term and longer-term approach to housing male and female inmates who may have a positive HTLV-III antibody test. The County has requested single cell accommodations which are isolated from the general population.

The short-term issue could be only a few persons: say 1-2 women and 4-5 men. The longer term is unknown, but is appears the number will increase. Isolated housing also implies access to services available to the general population.

Small numbers mean either special small housing modules, or loosing full use of larger standard housing modules. Larger number of AIDS persons in the longer term could see use of a standard module, which condition may be simpler administratively. The attached reprint, "Aids Presents Perplexing Legal Problems...", CORRECTIONAL LAW, W. Collins, 1986, explores the issue in more detail.

5.2 The County's written mental health policy related to Elmwood; (ie) written verification of the current client/user planning session discussions. This verification is in process with a written statement anticipated the week of 12/15/86.

County of Santa Clara
California

Office of the County Counsel
County Government Center, East Wing
70 West Hedding Street
San Jose, California 95110
299-2111 Area Code 408

Donald L. Clark, *County Counsel*

December 3, 1986

Attachment (g)

MEMORANDUM

TO: Supervisor Dianne McKenna
District Five

FROM: Joanne Hue
Deputy County Counsel

RE: AIDS Anti-Discrimination Ordinance

You have requested an opinion on behalf of the County AIDS Task Force regarding the extent of the County's jurisdiction to adopt an AIDS anti-discrimination ordinance affecting the following areas: housing, access to specified medical services, access to paramedical services, employment, educational institutions, banking and lending institutions, municipal services and employment, and HTLV-III testing.

This office concludes that the County has jurisdiction to enact an AIDS anti-discrimination ordinance affecting all of the above listed areas except for municipal services and employment, and educational institutions. However, such ordinance would only be effective in the unincorporated areas of the County

In general, the regulation of municipal services and employees are municipal affairs.

The regulation and operation of public schools are matters of statewide concern. The legislature is recognized as having complete power to legislate in this area, subject to constitutional restrictions. The County, therefore, is preempted from legislating in this area.

DISCUSSION

A city organized within the boundaries of a county is not subject to the legislative control of the county as to all matters the law, including the city charter, declares cognizable by the city. Re Application of Knight (1921) 55 Cal.App. 511. A city is entirely independent of a county, and is generally not subject to any local legislation by the county. Knight, supra.

Cities organized under the general laws of this state, are subject to such laws even as to local matters. Ex parte Jackson (1904) 143 Cal. 564.

Chartered cities have the power to legislate and enforce within their boundaries all ordinances and regulations with respect to municipal affairs, subject to the limitations provided in their charters. California Constitution Article XI §5.

Both types of cities may also adopt and enforce within their limits all local, police, sanitary and other ordinances and regulations not in conflict with general laws. California Constitution Article XI §7.

1. Paramedic services:

Each county is authorized to establish a county-wide emergency medical services program, which in this county is coordinated and monitored through the County Health Department. Health and Safety Code §1797.200.

However, a county does not have authority to coordinate the emergency medical services of a city if such city has contracted for or provided emergency medical services as of June 1, 1980 and has not entered into a written agreement with the county for the coordination and provision of such services within city boundaries. Health and Safety Code §1797.201.

In this county, the cities of Campbell and Palo Alto have chosen to continue providing emergency medical services through their fire departments. Aside of these two cities, the remaining areas within the county are divided into two zones and are served by three paramedic providers under contract with the County.

Any AIDS anti-discrimination ordinance involving access to paramedic services would be effective only in the unincorporated areas of the county. It is possible though that such an ordinance may indirectly produce the desired result county-wide since all providers (whether or not under contract with the County) operating around the unincorporated areas should anticipate having to provide services in the unincorporated areas.

Similarly, current emergency medical services providers under contract with the County would only be subject to a County AIDS anti-discrimination ordinance for those operations in the unincorporated areas of the county, or upon agreement to such a prohibition through written contract.

2. HTLV-III testing:

Currently, there is no State legislation which prohibits or limits a request to individuals to be tested for antibodies to the probable causative agent of AIDS. Various statutes have been passed on the subject of AIDS, which includes prohibiting the use

of antibody test results for determination of insurability or suitability for employment, and procedures for testing for antibodies at blood banks and alternative test sites.

An AIDS anti-discrimination ordinance prohibiting the testing for antibodies as a pre-condition, is therefore not preempted by current State legislation and would be effective in the unincorporated areas of the County.

3. Municipal services and employment:

Cities organized under the general laws of the State are controlled by the provisions of the general laws.

Chartered cities have the express power to make and enforce all ordinances and regulations with respect to municipal affairs, subject to the provisions in their charters. California Constitution Article XI §5.

"Municipal affairs" includes the hiring, paying and compensation of municipal employees, and the provision of municipal services (such as sewerage, streets and highways). California Constitution Article XI §5; Redwood City v. Moore (1965) 231 Cal. App. 2d 563.

As a result of these limitations, a county has no jurisdiction to enact an ordinance regulating municipal services and employment.

4. Educational institutions:

The establishment, regulation, and operation of public schools has been deemed a matter of statewide concern; these areas are covered by the State Constitution and the legislature has been given complete power in this regard subject to constitutional restrictions. Hall v. City of Taft (1956) 47 Cal. 2d 177. School districts are agencies of the state for the local operation of the state school system. Hall, supra. State legislative enactments affecting the public school system are generally controlling over attempted regulation by municipalities. Town of Atherton v. Superior Court (159 Cal. App. 2d 417.

A county is a political subdivision of the State. Government Code §23002. A county depends on State legislation to prescribe its powers, duties and obligations in exercising governmental functions on behalf of the State. Vagim v. Board of Supervisors (1964) 230 Cal. App. 2d 286. A county also has the power to adopt ordinances as an exercise of its "police powers" as

long as there is no conflict with general laws. California Constitution Article XI §7.

Due to the recognition of the plenary power of the legislature with regards to the public school system and the analogy posed by the fact that the constitutionally granted "police powers" of a city have been held not to empower a city to regulate a school district (Hall, supra), it is advised that any AIDS anti-discrimination ordinance is preempted by the general law and would not be a valid exercise of the "police powers" constitutionally granted to counties.

2327h/JH/1-4